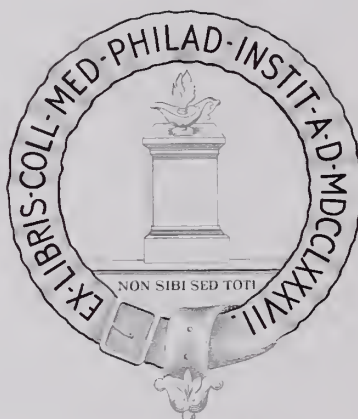


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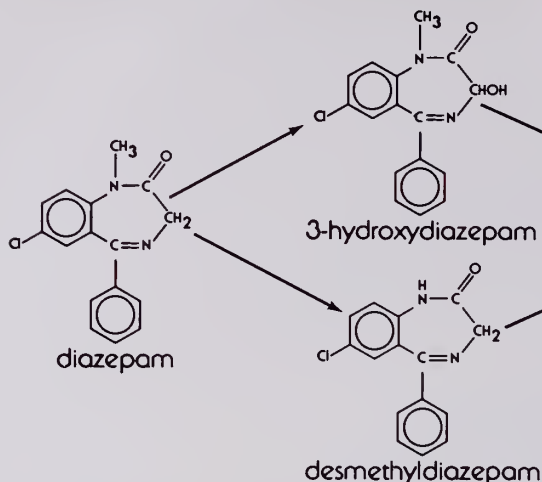
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FMA TO SPONSOR STATEWIDE TELEVISION SHOW TUESDAY, JANUARY 25, 1977

"A Matter of Life . . ."—The Story of Medical Service and Health Care in Today's Florida—See Page 34a

A pharmacokinetic character all its own



Valium (diazepam) is a benzodiazepine with a distinctive pharmacokinetic profile

The pharmacokinetic profile of Valium is one of the characteristics that sets it apart from other benzodiazepines. Consider, in particular, the metabolic pathway of Valium. The three major metabolites of Valium exhibit significant pharmacologic activity—and so, of course, does the parent substance—diazepam itself. All combine to produce the characteristic clinical response seen with Valium. The response you have come to know, to want and to trust.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due

to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma;

may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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JANUARY COVER — The cover was drawn by Dr. John Snow, of Jacksonville, who, in addition to being a Plastic Surgeon in private practice, is a gifted artist. This creative cover by Dr. Snow highlights the lead article in this issue, entitled "Mucocutaneous Lymph Node Syndrome in Florida," on page 21.



President's Page

Unity

"The American Medical Association is meeting here today, and it is a house divided." Thus blared the television set in the Sheraton Hotel room at 6:30 a.m., December 6, 1976, in Philadelphia. This is how the reporters saw us in the opening session of the House of Delegates, and rightly so since diverse opinions do exist on major issues such as a National Health Bill. The far more important news flash would concern the unity of the House at the closing session.

Unity remains the primary concern of all organizations, ever since men first discovered the strength of joining together. Without unity the strength of the organization declines, and we are again reduced to individuals bickering with one another.

The House of Delegates was specifically devised to provide an arena in which an orderly exchange of ideas can occur. The exchanges may be brief or lengthy. They may be heated or dispassionately cool, until all aspects of the topics are aired. This phase of activity should not be misconstrued as disunity. It is only after the final vote is taken, and the minority rejects the decision of the majority and refuses to abide by it, that disunity prevails.

The most pertinent example of the results of disunity to us, as physicians in the world today, is the plight of British medicine. It is well recognized that had British physicians stood united under strong leadership, the National Health Service could not have been imposed upon the British people. In this sense, the deterioration of medical care in Britian may be laid at the feet of the British doctors.

Our own House will convene this month, and with the new political situation in Washington this could be the most important meeting in the history of Florida medicine. We in the House of Delegates have an obligation to our patients and our colleagues to be as well informed as possible on the issues at hand, and strive to reach the best decisions possible. Then, I hope we accept the decisions of the majority, and adjourn united in purpose and action in carrying out these decisions.

I would surely hate for our actions to be exemplified by that famous quotation from the comic strip Pogo, "We have met the enemy, and he is us."

Jack A. Walvis, MD

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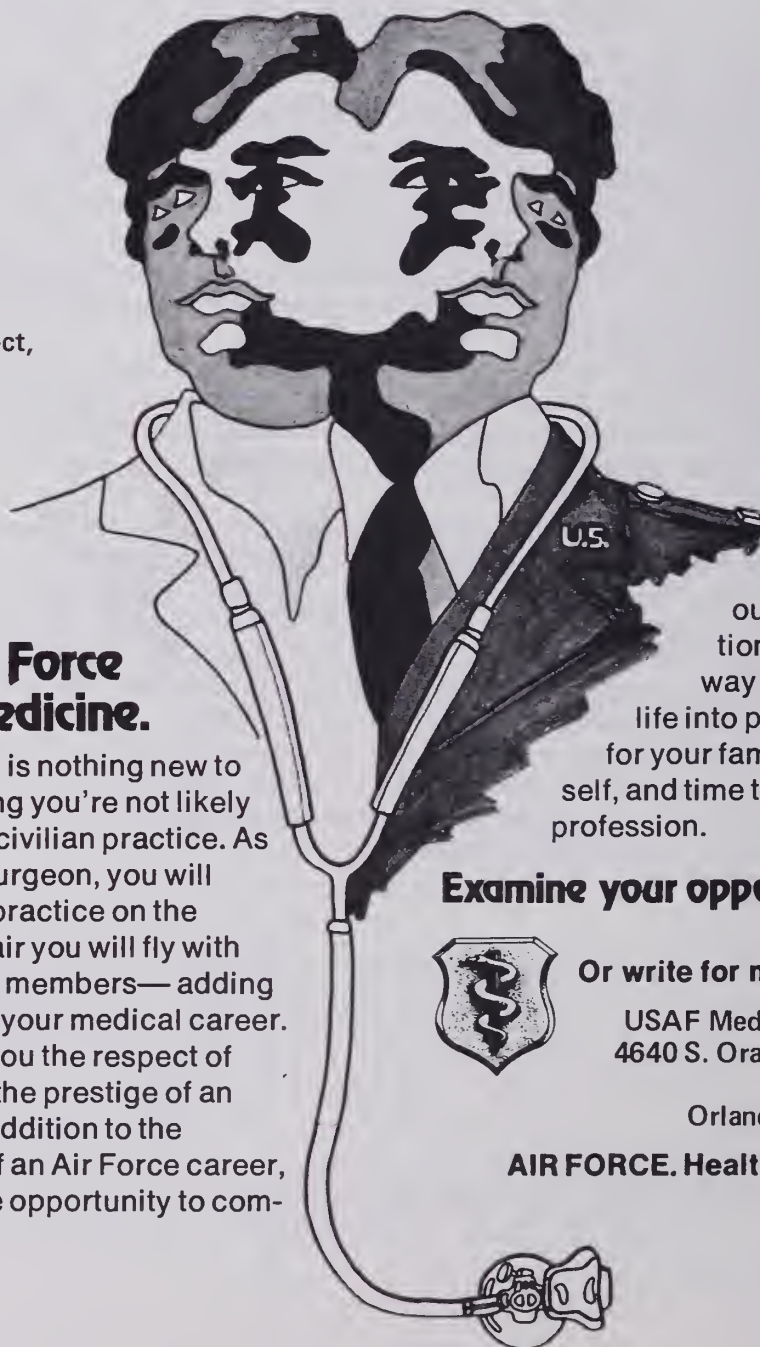
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*Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

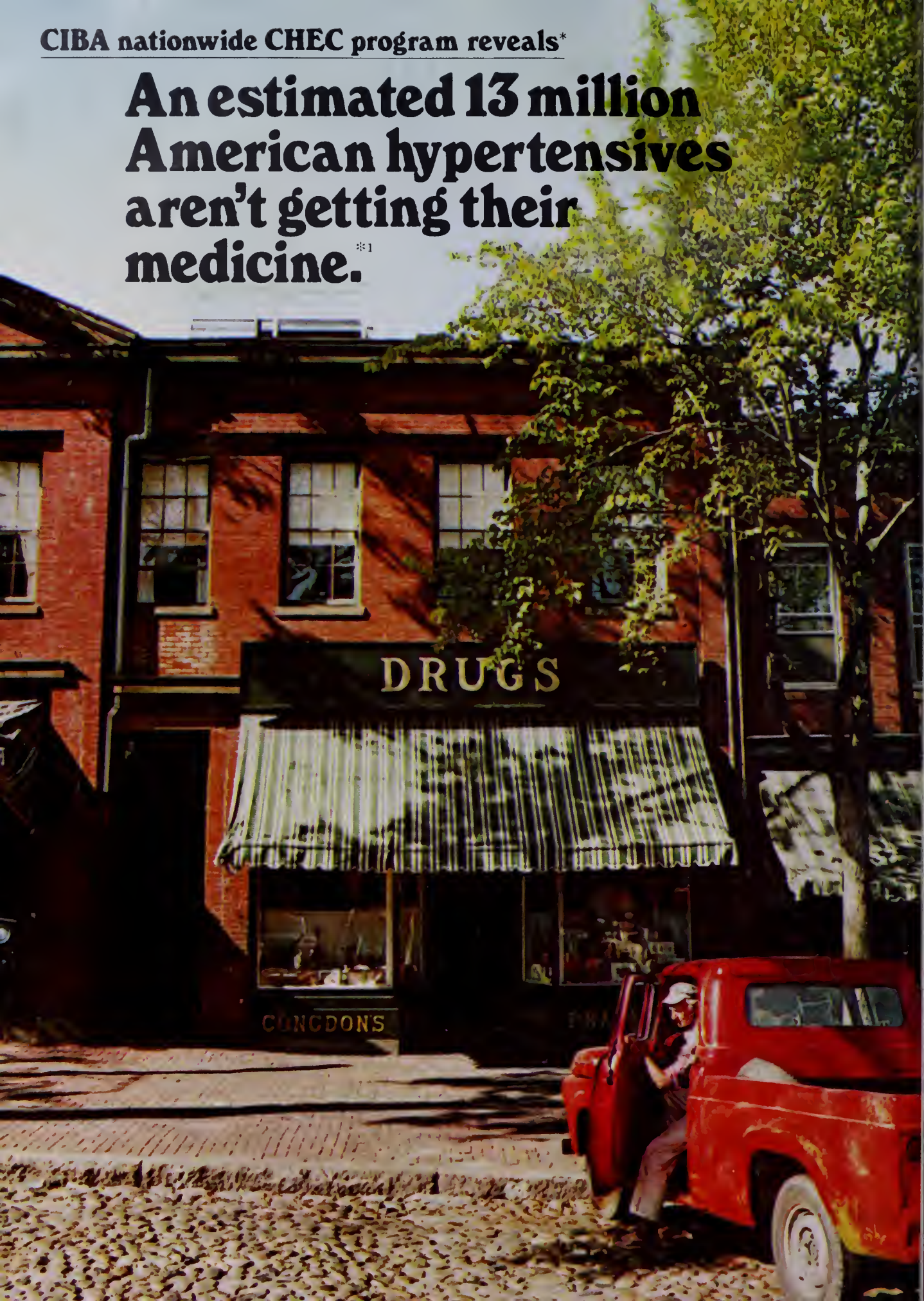
Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500, 1000, 5000 and Unit Dose.

CIBA nationwide CHEC program reveals*

**An estimated 13 million
American hypertensives
aren't getting their
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Here's one patient who has stayed with his regimen for 8 years.

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— which reduces body sodium and fluid volume. Reserpine completes the package by reducing sympathetic vascular tone.

Once dosage of individual components is titrated to your patient's needs, Ser-Ap-Es can be a logical choice for long-term therapy.

Use Ser-Ap-Es cautiously in patients with advanced renal damage or cerebrovascular accident. Discontinue at first sign of mental depression.

* CHEC (Community Hypertension Evaluation Clinic), the program that screened 1,049,225 Americans for hypertension, showed that 55.1% of the hypertensives screened were previously undetected, untreated, or uncontrolled. The 13 million figure is a projection based on this percentage and the estimated 24 million hypertensives in the United States. CHEC was a two-year, nationwide study sponsored by CIBA and local health organizations.¹

** Barney Platt is a pseudonym for an actual case history.

Please turn page for prescribing information.



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hydrochlorothiazide 15 mg

Therapy planned for life

Ser-Ap-Es®

reserpine 0.1 mg
hydralazine hydrochloride 25 mg
hydrochlorothiazide 15 mg

WARNING

This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

INDICATIONS

Hypertension. (See box warning.)

CONTRAINDICATIONS

Reserpine: Known hypersensitivity; mental depression (especially with suicidal tendencies); active peptic ulcer; ulcerative colitis; electroconvulsive therapy.

Hydralazine: Hypersensitivity; coronary artery disease; mitral valvular rheumatic heart disease.

Hydrochlorothiazide: Anuria; hypersensitivity to this or other sulfonamide-derived drugs.

WARNINGS

Reserpine: Use with extreme caution in patients with a history of mental depression. Discontinue at first sign of despondency, early morning insomnia, loss of appetite, impotence, or self-deprecation. Drug-induced depression may persist for several months after drug withdrawal and may be severe enough to result in suicide.

MAO inhibitors should be avoided or used with extreme caution.

Hydralazine: Hydralazine may produce in a few patients a clinical picture simulating systemic lupus erythematosus. In such patients hydralazine should be discontinued unless the benefit to risk determination requires continued antihypertensive therapy with this drug. Symptoms and signs usually regress when the drug is discontinued but residua have been detected many years later. Long-term treatment with steroids may be necessary.

CBC's, L.E. cell preparations, and antinuclear antibody titer determinations are indicated before and periodically during prolonged therapy with hydralazine or if the patient develops any unexplained signs or symptoms.

A positive antinuclear antibody titer and/or positive L.E. cell reaction requires that the physician carefully weigh the implications of the test results against the benefits to be derived from antihypertensive therapy with hydralazine. Use MAO inhibitors with caution.

Hydrochlorothiazide: Use with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects of the drug may develop in patients with impaired renal function.

Thiazides should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte imbalance may precipitate hepatic coma. Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs.

Sensitivity reactions are more likely to occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

Usage in Pregnancy

Reserpine: The safety of reserpine for use during pregnancy or lactation has not been established; therefore, the drug should be used in pregnant patients or women of childbearing potential only when, in the judgment of the physician, it is essential to the welfare of the patient. Increased respiratory tract secretions, nasal congestion, cyanosis, and anorexia may occur in neonates and breast-fed infants of reserpine-treated

mothers since reserpine crosses the placental barrier and appears in maternal breast milk.

Hydralazine: Animal studies indicate that high doses of hydralazine are teratogenic in mice, possibly in rabbits, and not in rats. Although clinical experience does not include any positive evidence of adverse effects on the human fetus, hydralazine should be used during pregnancy only if the benefit clearly justifies the potential risk to the fetus.

Hydrochlorothiazide: Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnant women requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

Nursing Mothers: Thiazides appear in breast milk. If the use of the drug is deemed essential, the patient should stop nursing.

PRECAUTIONS

Reserpine: Use cautiously in patients with history of peptic ulcer, ulcerative colitis, or gallstones (biliary colic may be precipitated).

Exercise caution when treating hypertensives with renal insufficiency. Use cautiously with digitalis and quinidine.

Intraoperative hypotension has occurred in hypertensive patients receiving rauwolfia preparations, but withdrawal of reserpine does not assure that circulatory instability will not occur in such patients.

Hydralazine: Use cautiously in suspected coronary artery or other cardiovascular disease, cerebral vascular accidents, and advanced renal damage. Postural hypotension may occur, and the pressor response to epinephrine may be reduced. Peripheral neuritis, evidenced by paresthesias, numbness, and tingling, has been observed. Published evidence suggests an antipyridoxine effect and addition of pyridoxine to the regimen if symptoms develop.

Blood dyscrasias, consisting of reduction in hemoglobin and red cell count, leukopenia, agranulocytosis, and purpura, have been reported. If such abnormalities develop, discontinue therapy. Periodic blood counts are advised during prolonged therapy.

Hydrochlorothiazide: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals. Observe patients for clinical signs of fluid or electrolyte imbalance (hyponatremia, hypochloremic alkalosis, and hypokalemia). Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbance such as nausea or vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of steroids or ACTH. Interference with adequate oral intake of electrolytes will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effects of digitalis (eg, increased ventricular irritability).

Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver diseases or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Latent diabetes may become manifest during thiazide administration. Thiazide drugs may increase the responsiveness

to tubocurarine. The antihypertensive effects of the drug may be enhanced in the post-sympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathological changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism such as renal lithiasis, bone resorption, and peptic ulceration have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

ADVERSE REACTIONS

Reserpine: *Gastrointestinal*—hypersecretion; nausea; vomiting; anorexia; diarrhea. *Cardiovascular*—angina-like symptoms; arrhythmias (particularly when used concurrently with digitalis or quinidine); bradycardia. *Central Nervous System*—drowsiness; depression; nervousness; paradoxical anxiety; nightmares; rare parkinsonian syndrome and other extrapyramidal tract symptoms; CNS sensitization (manifested by dull sensorium, deafness, glaucoma, uveitis, and optic atrophy). *Miscellaneous*—frequently nasal congestion; pruritus; rash; dryness of mouth; dizziness; headache; dyspnea; syncope; epistaxis; purpura and other hematologic reactions; impotence or decreased libido; dysuria; muscular aches; conjunctival injection; weight gain; breast engorgement; pseudolactation; gynecomastia; rarely water retention with edema in hypertensive patients.

Hydralazine: *Common*—headache; palpitations; anorexia; nausea; vomiting; diarrhea; tachycardia; angina pectoris. *Less frequent*—nasal congestion; flushing; lacrimation; conjunctivitis; peripheral neuritis, evidenced by paresthesias, numbness, and tingling; edema; dizziness; tremors; muscle cramps; psychotic reactions characterized by depression, disorientation, or anxiety; hypersensitivity (including rash, urticaria, pruritus, fever, chills, arthralgia, eosinophilia, and, rarely, hepatitis); constipation; difficulty in micturition; dyspnea; paralytic ileus; lymphadenopathy; splenomegaly; blood dyscrasias, consisting of reduction in hemoglobin and red cell count, leukopenia, agranulocytosis and purpura hypotension; paradoxical pressor response.

Hydrochlorothiazide: *Gastrointestinal*—anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic), pancreatitis, sialadenitis. *Central Nervous System*—dizziness, vertigo, paresthesias, headache, xanthopsia. *Hematologic*—leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia. *Cardiovascular*—orthostatic hypotension (may be potentiated by alcohol, barbiturates, or narcotics). *Hypersensitivity*—purpura, photosensitivity, rash, urticaria, necrotizing angitis, Stevens-Johnson syndrome, and other hypersensitivity reactions. *Other*—hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness. Whenever adverse reactions are moderate or severe, reduce dosage or withdraw therapy.

DOSAGE

As determined by individual titration (see box warning).

Usual dosage is 1 or 2 tablets t.i.d. For maintenance, adjust dosage to lowest patient requirement. When necessary, more potent antihypertensives may be added gradually in dosages reduced by at least 50 percent.

HOW SUPPLIED

Tablets (light salmon pink, dry-coated), each containing 0.1 mg reserpine, 25 mg hydralazine hydrochloride, and 15 mg hydrochlorothiazide; bottles of 30, 60, 100, 1000 and Accu-Pak® blister units of 100.

Consult complete literature before prescribing.

CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901

Reference

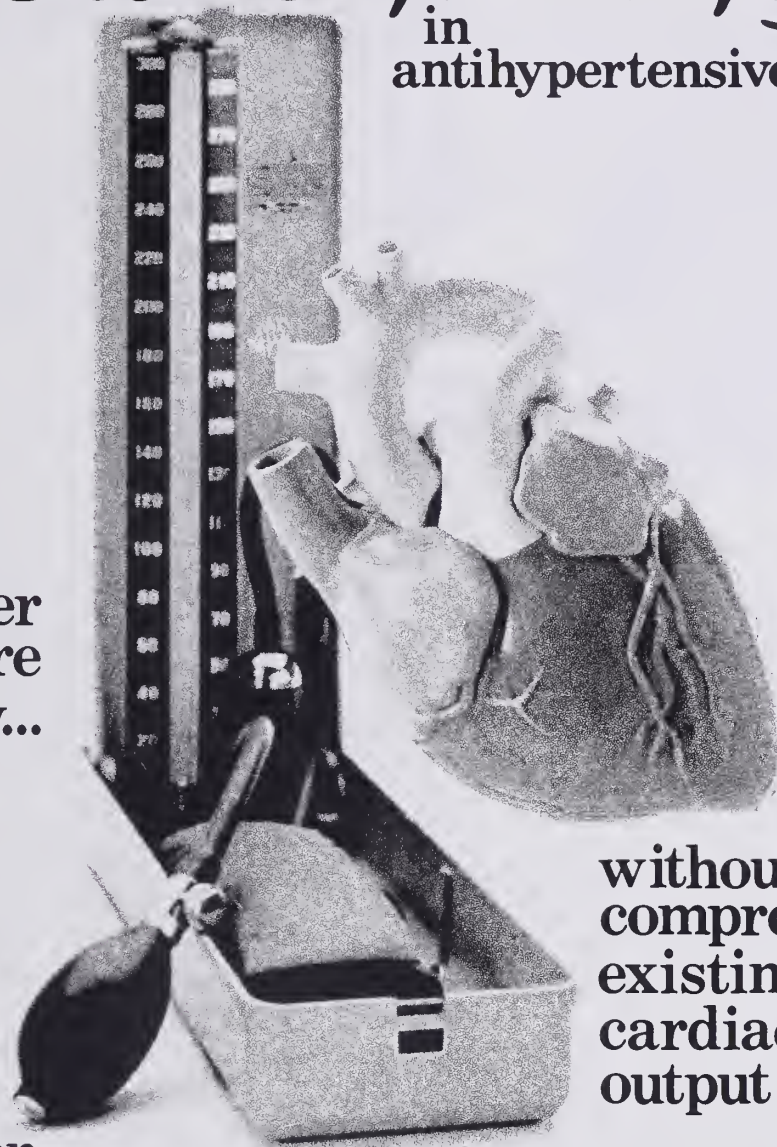
1. Stamler J, Stamler R, Riedinger WF, et al: Hypertension screening of 1 million Americans. *JAMA* 235:2299-2306, 1976.

C I B A

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to lower
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without
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in hypertension

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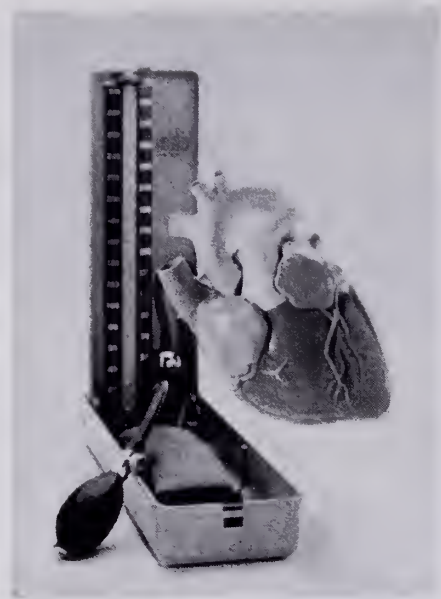
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cardiac function—cardiac output
is usually maintained

ALDOMET is contraindicated in active hepatic disease, hypersensitivity to the drug, and if previous methyldopa therapy has been associated with liver disorders. It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

For a brief summary of prescribing information, please see following page.

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effectively...
usually with no
direct effect on
cardiac function—
cardiac output is
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Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis; if previous methyldopa therapy has been associated with liver disorders (see Warnings); hypersensitivity.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or

cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Use in Pregnancy: Use of any drug in women who are or may become pregnant requires that anticipated benefits be weighed against possible risks; possibility of fetal injury can not be excluded.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decreased mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease daily dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatus, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia. Leukopenia, granulocytopenia, thrombocytopenia.

Allergic: Drug-related fever, myocarditis.

Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, dermatologic reactions including eczema and lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited to 500 mg daily when given with antihypertensives other than thiazides. Tolerance may occur, usually between second and third month of therapy; increased dosage or adding a thiazide frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Syncope in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease: this may be avoided by lower doses.

How Supplied: Tablets, containing 125 mg methyldopa each, in bottles of 100; Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486 J6AM07 (707)

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Fort Lauderdale, Florida

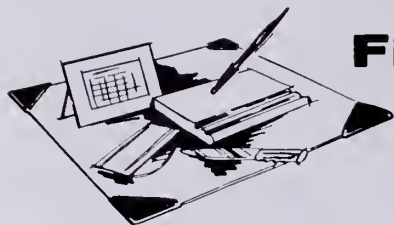
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FROM THE EDITOR'S DESK

Part "B" Medicare claims have been handled by Blue Shield for all or most of Florida since July 1, 1966. Total payments processed to August 31, 1976, amount to \$1,374,027,551. And speaking of Medicare, Blue Shield has a pamphlet entitled "Six Helpful Hints to Speed Up Your Part B Payments," which is available to beneficiaries upon request.

* * * *

Three federal judges have been named to hear AMA's constitutional challenge of the National Health Planning and Resources Development Act. They are Judge J. Braxton Craven Jr., of the U.S. Fourth Circuit Court of Appeals, and U.S. District Judges John D. Larkins Jr., and F. T. Dupree Jr., both of Raleigh, N.C.

* * * *

Virginia's attorney general is investigating an organization called Malpractice Research, Inc., of Herndon, Va., according to the Medical Society of Virginia. Advertising appearing in several states offers large fees to nurses who report incidents of possible negligence.

* * * *

The formation of the new State Health Coordinating Council (SHCC) is now complete with the appointment of its 31 members. There are 16 consumers and 15 health care providers on the Council, the latter including only three medical doctors. The Council will oversee Florida's nine Health Systems Agencies (HSAs) as provided in the National Health Planning and Development Act.

* * * *

As this issue of **The Journal** reaches its readers, many county medical societies will be in the midst of receiving and checking continuing medical education reports of their members. The Florida Academy of Family Physicians is trying to make the

job easier for county medical societies as they process reports of the first three-year cycle of the FMA-CME program. FAFP will provide societies with verification when its members meet their educational requirements.

* * * *

FLAMPAC has announced the appointment of three new members of its Board of Directors. They are: Donald O. Alford, M.D., Tallahassee; John C. Kruse, M.D., Jacksonville; and Harold Williamson, M.D., Tampa.

* * * *

The AMA Committee on Transfusion and Transplantation is promoting a more active physician role in blood banking and blood usage. A new publication, "Guide for Hospital Committees on Transfusions," outlines the organization of a hospital transfusion committee. There are also sections on suggested activities of transfusion committees, blood banking facilities and Medicare services.

* * * *

Proceedings of the 1975 AMA Conference on the Medical Aspects of Sports have been published. Copies are available from the AMA Order Department at \$7.50 each for 1-10 copies, less for larger orders.

* * * *

Congress has been advised that payment of fees closer to usual and customary is the key to solving physician reimbursement problems under Medicare. AMA Board Chairman Raymond T. Holden, M.D., told a House Ways and Means subcommittee that physician charges are based on data as much as two years old. This puts physicians in the position of absorbing today's increased costs while being paid on the basis of yesterday's charges.

Beginning in 1977, members of the Kentucky Medical Association will be required to hold membership in the American Medical Association. Four other states—Arizona, Hawaii, Illinois and Wisconsin—also have “unified” membership.

* * * *

President Ford has signed legislation relaxing federal requirements for health maintenance organizations (HMOs). Major provisions eliminate the requirement for “open enrollment” periods and permit private physicians to work parttime for HMOs.

* * * *

The AMA House of Delegates, meeting in Philadelphia last month, had before it a proposal that a Section on Medical Schools be established. The Board of Trustees said the section would give medical school officials a voice in policy-making affecting their institutions. The decision on the matter was not available as this issue of **The Journal** went to press.

* * * *

AMA will offer four optional seminars at its National Leadership Conference in Chicago on January 20. Fees will be charged and limited registration will be imposed for workshops on “Improving Practice Productivity,” “Mastering Spokesmanship Principles,” “Honoring Your Political Skills,” and “Mr. Chairman: How to Run and Control Your Meeting.”

* * * *

The Joint Commission has developed a program on hospital accreditation standards for administrators, medical staff leadership, and others. The program has been approved for 10½ hours of AMA Category 1 credit. Information on dates and locations may be obtained from the JCAH, 875 N. Michigan Ave., Chicago, Ill. 60611.

* * * *

Blue Shield has found that cost is the most common reason groups cancel their coverage. Service, particularly in the major medical area, runs second.

* * * *

Ceremonies in Washington, D. C., welcomed the charter class of 32 students at the new Uniformed Services University of the Health Sciences. The five women and 27 men will prepare for medical careers in the three military services and the Public Health Service.

* * * *

Blue Cross - Blue Shield reports 1,352 of its Jacksonville employees have opted for medical coverage of the Individual Practice Association Health Maintenance Organization (HMO). The HMO is sponsored by the Jacksonville Area Foundation for Medical Care.

* * * *

Blue Shield's Professional Relations Committee has been studying the possible installation of terminals throughout the State for the automated filing of physician claims. The facilities would be available to subscribers filing claims as well as to physicians without terminals in their offices. Physician reaction to the concept is being sought through the county medical societies.

* * * *

Like the nickel cup of coffee, reasonably priced professional liability insurance is a relic of the past. According to the AMA, the average malpractice premium was only \$610 in 1968 but skyrocketed to \$7,887 in 1975.

* * * *

The government has suffered a defeat in the federal court system in its efforts to move against questionable and quack remedies. The federal appeals court in Denver, siding with a lower court, in effect allowed a cancer patient to buy and transport the controversial product, Laetrile. The higher court sidestepped the questions of Laetrile's effectiveness and the Food and Drug Administration's right to bar it from the market. The lower court had ruled that Laetrile was effective and that FDA acted unconstitutionally in seeking to curb it.

The Editor

New Study Just Released!

Important information for physicians about generics

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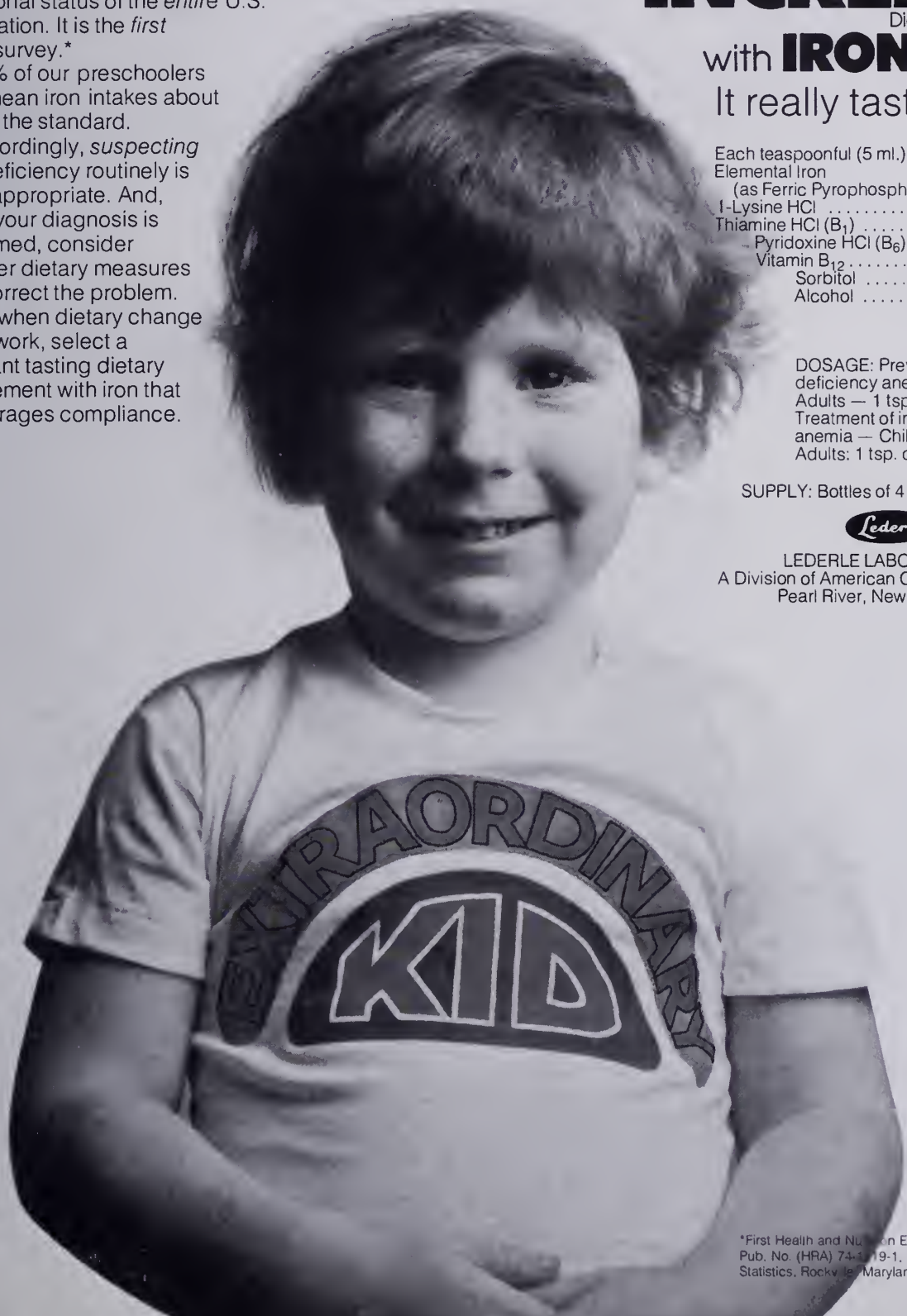
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Vitamin B ₁₂	25 mcgm
Sorbitol	3.5 Gm
Alcohol	0.75%

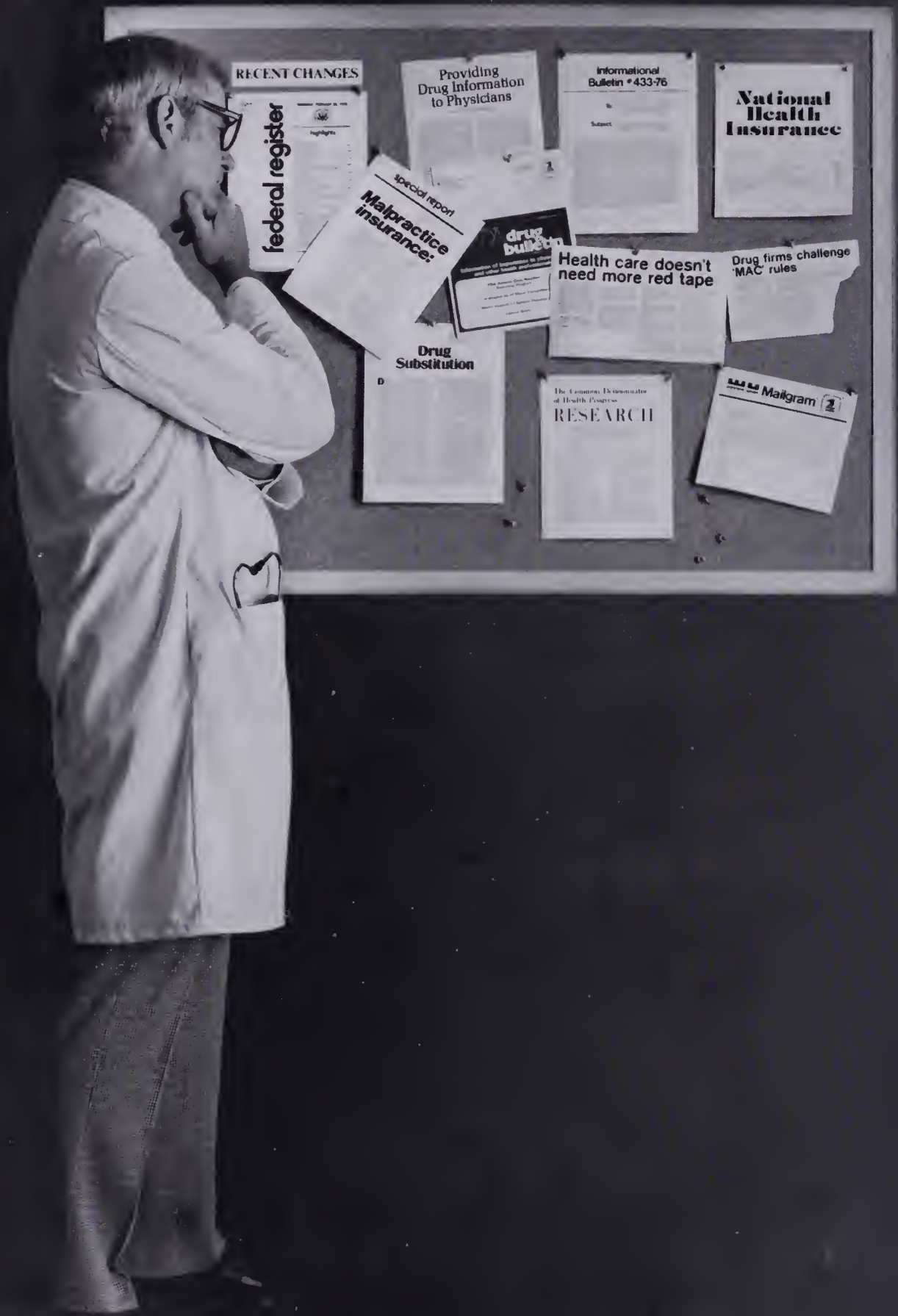
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*First Health and Nutrition Examination Survey, DHEW Pub. No. (HRA) 74-119-1, National Center for Health Statistics, Rockville, Maryland.



RECENT CHANGES

federal register

Providing
Drug Information
to Physicians

Informational
Bulletin #433-76

National
Health
Insurance

special report
Malpractice
insurance:

drug
bulletin

Health care doesn't
need more red tape

Drug firms challenge
MAC rules

Drug
Substitution

The Common Denominator
of Health Progress
RESEARCH

Mailgram 2

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



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Mucocutaneous Lymph Node Syndrome in Florida

Michael K. Dennis, M.D., Elia M. Ayoub, M.D., Toney Graham, M.D.,
 Kenneth Horn, M.D., George Y. Elson, M.D. and William P. Hadley, M.D.

Abstract: Three cases of mucocutaneous lymph node syndrome are reported. Two of the children were black. The three patients presented with characteristic manifestations of the disease: persistent fever, cervical lymphadenopathy, conjunctivitis, an enanthem with marked erythema of the lips, mucous membranes and a "strawberry tongue," and a polymorphous exanthem associated with prominence of the rash in the palms and soles during the acute stage of illness. The typical desquamation at the tips of fingers and toes occurred in all patients during convalescence. Laboratory findings included marked leukocytosis with "shift-to-left," elevated erythrocyte sedimentation rate, positive C-reactive protein and increased number of leukocytes in voided urine. Throat, blood, cerebrospinal fluid and urine cultures were negative for bacterial pathogens. Streptococcal antibody titers were normal. In one patient, the onset of disease followed booster immunization. All patients recovered uneventfully.

Mucocutaneous lymph node syndrome (MLNS) is a clinical entity characterized by persistent fever, lymphadenopathy, an enanthem and exanthem.^{1,2} The syndrome was first encountered in Japan and described by Kawasaki in 1967.¹ To date over 6,000 cases have been recorded in that country. In contrast to the high prevalence among Japanese, only about 15 sporadic cases have been reported in the continental United States.³⁻⁸ These reports comprise cases from several states. Three documented cases of the disease in Florida are the subject of this report.

Report of Cases

Case 1.—The five-year, eight-month-old white male experienced sudden onset of fever ranging up to 41°C on 7/27/76. The next morning marked swelling of the right side of his neck was noted. On 7/29/76 a rash was seen which started on the neck and progressed to the axillae, trunk and groins. The initial lesions were erythematous, nonvesicular and measured 1-2 cm in size. These subsequently became confluent. At the same time, the mother noted that the tips of his fingers were "fiery red." This severe erythema became evident shortly in his palms and soles. In addition his lips became very red and on the next day showed mild fissuring. At this time conjunctivitis was noted which consisted of prominence of the bulbar vessels with a subconjunctival hemorrhage in the right eye, but no exudate. Shortly after appearance of the rash, vomiting and diarrhea developed which lasted for three days. These were associated with anorexia. On 8/2/76 the patient complained of pain in the left ankle with difficulty in walking and was referred to the Shands Teaching Hospital Pediatric clinics for evaluation.

The fever, adenitis, and conjunctivitis persisted until 8/3/76 when the patient was seen in our clinic. In the interim, the skin rash and palmar erythema regressed almost completely and were followed by onset of peeling of the skin in the axillae and perineum.

On physical examination the patient looked acutely ill and complained of pain in his left wrist and both ankles. His temperature was 38°C. There was faint erythema around the neck with mild desquamation in the axillae and intergluteal area. Marked congestion and prominence of the bulbar vessels were seen in both eyes with a subconjunctival hemorrhage in right eye (Fig. 1). The lips were crimson-colored and fissured (Fig. 2). The tongue was very erythematous with papillary hypertrophy (Fig. 3). Right upper cervical adenopathy was present with two large nodes measuring 2-3 cm in diameter and which were discrete and nontender. Auscultation of the heart revealed tachycardia (110/min), and a grade II/VI, high-pitched systolic flow murmur in the second and third left intercostal spaces. This murmur had been noted previously by the referring pediatrician in March 1975. There was no hepatosplenomegaly. Minimal edema of the glans penis and some desquamation of the skin in that area were noted. The left wrist and both ankles were moderately swollen, tender and exquisitely painful to flexion.

The peripheral white blood cell count (WBC) was 16,700/cu mm with 82% PMN and 6% stabs. Platelets were 610,000/cu mm. Erythrocyte sedimentation rate (ESR) was 106 mm/h and the C-reactive protein (CRP) was positive. Urinalysis showed 1+ protein and 20-25 WBC/HPF. Both throat and urine cultures were negative.

From the Department of Pediatrics, University of Florida College of Medicine, Gainesville, and the University Hospital, Jacksonville.

The immunoglobulin and complement levels were IgG 1250 mg%, IgM 250 mg%, IgA 175 mg%, IgE 370 IU/ml (normal range for age 7-103 IU/ml), C₃ 225 mg% and C₄ 47 mg%. The serum glutamic pyruvic transaminase (SGPT) and serum glutamic oxalacetic transaminase (SGOT) were normal. The chest roentgenogram and EKG were normal.

The patient's condition improved during the following two days of hospitalization with resolution of fever, lymphadenopathy and arthritis. On 8/6/76 he was discharged and that evening he exhibited onset of peeling of skin at the tips of his fingers and toes starting around the nail beds. This progressed to involve the palms and soles, was maximal on the 4th day following discharge and still evident when the patient was seen on follow-up in the clinic on 8/13/76 (Fig. 4). The patient was asymptomatic and the physical examination, except for residual mild conjunctivitis, was normal. On 8/16/76, the mother reported that the child had a limp in his right leg, suggesting recurrence of his arthritis, but otherwise he was well.

Case 2.—The patient a 15-month-old black female, was in her usual good state of health when she received her immunizations of DPT, OPV and MMR. Later that day low grade fever developed. The following day she had a temperature of 39.5C, followed by an erythematous maculopapular rash over the trunk and neck. One day later the mother noted the palms and soles to be quite red. At that time she experienced vomiting and occasional loose stools. Four days later, because of persistent fever, she was seen in the emergency room of a local hospital. Examination at that time disclosed bilateral enlarged cervical nodes. She was treated with Actifed® for congestion. The next day she returned with an urticarial rash over the trunk and a temperature of 40.2C. She was hospitalized. Peripheral WBC was 15,000/cu mm with 80% PMNs. Clean catch urine revealed pyuria (100-150 WBC/HPF). She was treated with ampicillin for the "infection" and with Decadron for the rash. A suprapubic tap was performed which yielded urine showing 1-2 WBC/HPF and was sterile on culture. On the third hospital day, the temperature was 40C and peripheral WBC was 23,000/cu mm with 83% PMNs. The next day she was transferred to Shands Teaching Hospital. Physical examination at that time revealed striking erythema of lips and mouth with "strawberry tongue." A nonpurulent conjunctivitis was present. There was questionable cervical adenopathy and a mild, brawny edema of both hands and feet. No rash was apparent. However desquamation in the inguinal region was seen in the area of the previously described rash. Chest roentgenogram and EKG were normal. Peripheral WBC was 30,000/cu mm with 75% PMNs. Urinalysis showed no cells. CSF was normal. ESR was 40 mm/h and the platelet count was 500,000/cu mm. A throat culture showed normal flora. Blood, urine and CSF cultures were negative. Streptococcal antibody titers were normal. IgE was 140 IU/ml (normal range for age 6-53 IU/ml). The child received no medication and continued to show spiking fever until the 12th day of illness when she became afebrile. At that time the WBC was 12,300/cu mm with 62% PMNs. Two days thereafter the child began having desquamation around the nail beds at the tips of her fingers as well as the toes and soles. Desquamation with pruritis was the only residual symptom which persisted for two weeks following discharge.

Case 3.—The 21-month-old black female was well until three days prior to admission when anorexia and fever developed and an erythematous rash on hands and feet. The next day the rash spread over the entire body. The rash was maculopapular and became pruritic on the day of admission. At this time the eyes showed a yellow coloration. On admission her temperature was 39C. Physical examination revealed an erythematous maculopapular rash over the hands, feet and trunk. She had scleral icterus and conjunctival injection. Right cervical node enlargement was present.

The WBC on admission was 16,600/cu mm with 88% PMNs and an ESR was 61 mm/h. A throat culture was negative for β -hemolytic streptococcus. The serum bili-

rubin was 6.5 mg% and the SGOT 44 IU/L. A clean catch urine revealed 50-60 WBC/HPF. The CSF had one WBC/cu mm. EKG and chest roentgenogram were normal. No therapy was instituted and the patient continued to be febrile until the seventh hospital day. Adenopathy slowly resolved over this period. On the fourth hospital day a WBC count was 27,000/cu mm with 61% PMNs. Bilirubin became normal by the fifth hospital day. The following day desquamation around the nail beds of both thumbs developed, and progressively over the next four days peeling of the skin spread to the region around the nails of all fingers and toes. On the 11th hospital day the patient had been afebrile for four days, the WBC count was 11,800/cu mm with 46% PMNs and she was discharged home in good condition.

Comment

The major clinical manifestations of MLNS are outlined in Table 1. All these features were encountered in the three patients seen by us.

Fever is high and spiking, persists for at least seven days with an average duration of ten days. Antibiotics and antipyretics have little effect on the febrile course. Conjunctivitis consists mainly of engorgement of bulbar vessels (Fig. 1). There is no discharge or edema. Lymphadenopathy is usually manifest by marked enlargement of one or two cervical nodes. These are minimally tender and nonsuppurative. The enlarged nodes usually appear within the first three days and persist throughout the febrile course.

The enanthem and exanthem in MLNS are very impressive. There is marked erythema and sometimes fissuring of the lips (Fig. 2). The tongue is very erythematous and the papillae are hypertrophic, imparting an appearance which is strikingly similar to the "strawberry tongue" of scarlet fever (Fig. 3). The exanthematous rash associated with MLNS appears within one to five days of the onset of fever. It is polymorphous, is generally erythematous and maculopapular but is not vesicular or crusted. The rash involves the face and trunk more than the proximal part of the extremities. Desqua-

TABLE 1.—Manifestations of Mucocutaneous Lymph Node Syndrome.

Major Clinical Manifestations

- Fever persisting for 7 days or more
- Conjunctival congestion without exudate
- Erythema of lips, oropharynx and tongue, with hypertrophy of papillae of tongue
- Polymorphous rash without vesicles
- Reddening of palms and soles with indurative edema
- Desquamation starting at fingertips during convalescence
- Cervical adenopathy

Other Manifestations

- Diarrhea and vomiting
- Arthralgia or arthritis
- Aseptic Meningitis
- Mild hepatitis
- Urethritis
- Heart murmur, gallop rhythm

mation in areas of severe involvement may be seen with recovery. Although usually nonpruritic, pruritis has been reported in some patients.⁷ One of our patients had marked pruritis from onset of rash and another experienced pruritis during the desquamation stage. Changes in the hands and feet in MLNS consist of brawny edema and deep erythematous (crimson) discoloration of palms and soles. These changes occur early in the course of the disease and may last for 5-15 days. Following subsidence of fever and rash, usually two to three weeks from onset, peeling of the skin occurs at the tips of fingers and around the nail beds (Fig. 4). This phenomenon is a characteristic finding. Its occurrence in conjunction with the above manifestation should be diagnostic of the syndrome.

Other symptoms associated with MLNS are a transient gastroenteritis with vomiting and diarrhea, mild hepatitis with increased serum transaminases, arthralgia or arthritis, and evidence of mild aseptic meningitis. Pyuria is a common finding. Although leukocytes are present in clean-voided urine, suprapubic taps show only a few WBC and the cultures are sterile. This finding is believed to be secondary to urethritis, another manifestation of mucosal inflammation.

Of laboratory findings (Table 2), leukocytosis with predominance of polymorphonuclear leukocytes (shift to left) is characteristic. Other acute phase reactants are also abnormal; the ESR is elevated and CRP is positive. Thrombocytosis is present during acute stage and platelet counts as high as 1 million/cu mm have been recorded. Serum electrophoresis may reveal elevated alpha₂ globulin. Elevated IgG levels as well as significant IgE elevation has been reported in this disease.⁹ Bacteriologic and virologic studies of blood, CSF, urine and stools yield negative results.

The course of the disorder in one of our patients (Case 1) is illustrated in Figure 5. This course is fairly typical of children with MLNS. The prognosis is quite benign, barring occurrence of the cardiac

complication which accounts for the 1-2% mortality associated with the syndrome. Thrombosis of the coronary vessels with severe myocardial infarction may occur.^{2,5,10,11} In addition, several patients with arteritis and microaneurysms of major vessels, including coronary vessel aneurysms, have been described.^{11, 12} The occurrence of microaneurysms in this disease is the reason for misdiagnosing some patients with MLNS as having infantile polyarteritis nodosa.

MLNS also is commonly confused with four diseases which make up the major components of the differential diagnosis. These are scarlet fever, atypical measles, juvenile rheumatoid arthritis and Stevens-Johnson syndrome.

Scarlet fever and MLNS have many common findings including "strawberry tongue," cervical lymphadenopathy, elevated WBC count with shift to the left and the erythematous maculopapular rash. The rash in scarlet fever shows the characteristic exaggeration in the skin folds of the axilla, groin, and antecubital fossa. Also common to the two diseases is development of desquamation which in scarlet fever begins within the first week and spreads over the entire body ending with the finger tips. In MLNS the peeling is unique in that it starts initially on the finger tips, around the nails. Other major points that differentiate MLNS from scarlet fever include failure to isolate streptococcus from throat culture studies, normal streptococcal antibody studies (ASO, streptozyme, etc.) during convalescence, failure of response to antibiotics and the prolonged febrile course.

Atypical measles is also a common diagnosis that is made when children are first seen with MLNS. They both present with fever, erythematous maculopapular rash which, in atypical measles, usually begins in the extremities. Atypical measles may also produce desquamation but not the typical fingertip distribution seen in MLNS. Both diseases also present with photophobia and nonpurulent conjunctivitis. In contrast to MLNS, which occurs primarily in young children, atypical measles is seen usually in children eight years of age or older.

Systemic juvenile rheumatoid arthritis (JRA) may present with a picture very similar to MLNS. Rash, leukocytosis, and lymphadenopathy may accompany fever in systemic JRA. The rash of JRA is similar to that of MLNS but usually is more salmon-pink and the palms and soles do not show the deep erythematous appearance seen with MLNS. Both diseases may be associated with arthritis of small and large joints. The brawny edema of hands

TABLE 2.—Laboratory Findings in Mucocutaneous Lymph Node Syndrome.

Leukocytosis with shift to left
Increased erythrocyte sedimentation rate
Positive C-reactive protein
Thrombocytosis
Elevated IgE
Proteinuria and pyuria on clean-catch urine, but negative on suprapubic tap. Sterile urine.
Throat culture negative for Group A streptococci
Normal streptococcal antibody titers



Fig. 1.—Bilateral conjunctivitis with subconjunctival hemorrhage in right eye. There is marked engorgement of vessels in bulbar conjunctivae but no exudate.



Fig. 2.—Marked erythema and fissuring of lips seen in patient during acute illness, a prominent finding in patients with MLNS.



Fig. 3.—Stomatitis in MLNS as reflected by erythema and hypertrophy of papillae on surface of tongue (strawberry tongue).



Fig. 4.—Peeling of skin at tips of toes, starting at junction of nailbeds and skin. This manifestation which occurs during convalescent stage of disease is pathognomonic of MLNS.

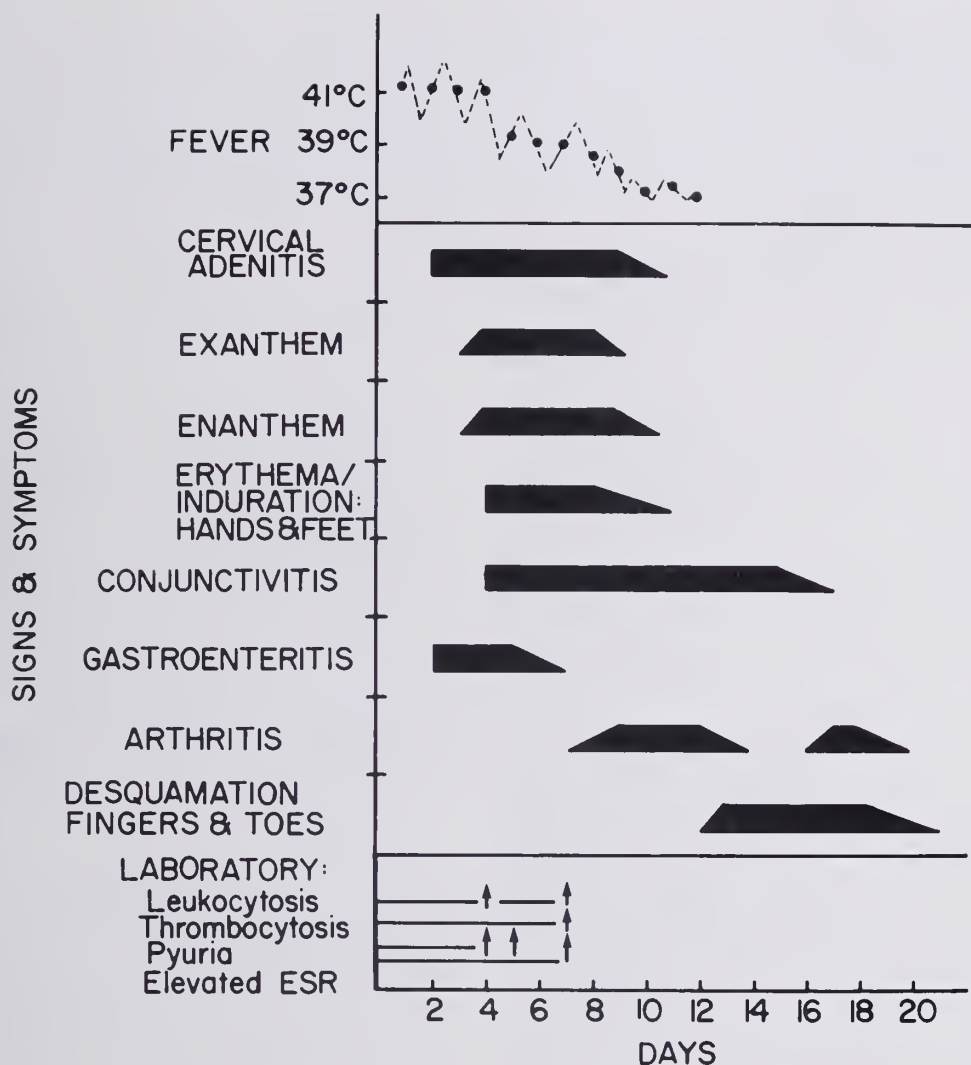


Fig. 5.—Onset and duration of manifestations in patient. This course is typical of the disease.

and feet seen in MLNS is usually not found in JRA. Thrombocytosis occurs in both diseases. The presence of stomatitis, brawny edema of hands and feet, desquamation, pyuria and the self-limited course generally differentiate MLNS from JRA.

Stevens-Johnson syndrome has many common features with MLNS such as fever, rash, conjunctivitis, stomatitis and urethritis. The rash of Stevens-Johnson is distinguished by the presence of bullae and substantial exfoliation. Oral findings in Stevens-Johnson are characterized by severe ulcerations with cracking and bleeding of lips. Conjunctival involvement in Stevens-Johnson is more severe with edematous conjunctivitis, profuse purulent exudate and possible progression to keratitis, iritis, and uveitis. Changes in hands and feet seen in MLNS have not been described in Stevens-Johnson syndrome.

Other diseases that should be entertained in the differential diagnosis of MLNS include enteroviral exanthems, rickettsial diseases and drug sensitivity reactions.

The epidemiology of MLNS is intriguing. As mentioned previously, the majority of patients described were Japanese or of Japanese descent.^{1, 2, 5} One of the cases reported from the continental U.S.A.⁸ represents an 18-month-old girl born to Caucasian parents. Of interest is that the patient, daughter of an U.S. Air Force dependent who was stationed in Japan, had returned with the family to Florida only a few months prior to the onset of her disease.¹³ None of the three cases reported here had lived outside Florida. The cases reported to date in the continental U.S.A. were all white children.^{3, 4, 6, 8} If so, two of our patients represent the first description of this syndrome in black chil-

dren. The age of maximal incidence is between one and two years and the majority of patients are under ten years of age. The disease is somewhat more common in boys. Our three patients were seen in June and July, reflecting the reported higher incidence of MLNS during summer.²

The etiology of MLNS remains obscure. Extensive studies have not yielded evidence of bacterial or viral association. Because many manifestations of this syndrome simulate rickettsial disease, the report by Hamashima¹⁴ on the presence of rickettsial-like bodies in tissue specimens was enthusiastically received. However the lack of confirmation of this finding by others and the unresponsiveness of the disease to antibiotics do not support the rickettsial etiology.¹⁵

Many features of this disease are analogous to those of acrodynia or Pink's disease. The possibility that MLNS, like acrodynia, is a manifestation of mercury poisoning was suggested by other investigators.¹⁶⁻¹⁸ Of interest is that Nashida¹⁸ proposed that the mercury may come from the preservative "thiomersal" which is present in various immunogens given to children. The apparent relationship of the onset of the disease to immunization in one of our patients (Case 2) prompted an investigation which revealed that 0.01% thiomersal was used as a preservative in the DPT immunogen given to this patient. This relationship however remains speculative and arguments against it include the fact that the amount of mercury present in 0.5 ml of DPT is rather small, that no relationship to immunization is consistently elicited in patients with this syndrome and that studies of the hair of these patients by Kawasaki¹⁷ failed to reveal abnormal levels of mercury.

As long as the etiology remains obscure, treatment of MLNS is purely supportive. The use of antibiotics or steroids has been shown to be ineffective. In patients with the vascular complications, surgical intervention is recommended only when the

lesion imposes a threat to the life of the patient. Recent reports suggest that vascular aneurysms associated with this disease gradually regress and disappear.¹⁹ This phenomenon represents another of the many perplexing facets of a newly described and rather mysterious disease.

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REVIEWERS' COMMENTS

This is an important report which should alert all who care for children about this entity—It might save some unnecessary evaluations.—James A. Hallock, M.D., Tampa.

A very interesting and timely article. I would recommend its publication.—Malcolm M. Traxler, M.D., Panama City.

Mesenteric Lymphangioma With Chylous Ascites

Adrian R. Jensen, M.D., Thomas J. Philpot, M.D. and Rudolfo Bustamonte, M.D.

Abstract: Mesenteric lymphangioma is an unusual cause of abdominal tumor in infancy. Obstruction of the defective lacteals results in accumulation of chyle in the mesentery with resultant inflammation, chylous ascites, and partial intestinal obstruction. Treatment should consist of complete excision of the lymphangioma if possible. If it is too extensive to resect without sacrificing too much intestine or other vital structures, the bulk of the tumor should be removed and the infant placed on a medium-chained triglyceride diet to decrease the production of chyle.

Case Report

A seven-month-old male infant was admitted with a history of intermittent attacks of fever, irritability, diaphoresis, vomiting and diarrhea. The infant had five such attacks beginning at three months of age. During the attacks, which lasted several days, he would refuse food and only drink water. Despite these attacks his growth and development were normal.

Physical examination revealed a well-developed, well-nourished healthy-appearing infant with a large mass in the left upper abdomen. The mass was hard, partially movable, and about 12 x 8 cm in size with the main expansion being transverse. Hemogram, electrolytes, chemistry profile, urinalysis, chest xray, intravenous pyelogram and barium enema were normal. Upper gastrointestinal series showed slight upward displacement of the stomach and some separation of loops of small intestine suggesting an abdominal mass.

At abdominal exploration there was a large mass involving the mesentery of the jejunum. The peritoneal cavity contained about 150 cc of milky fluid. The mass extended from the root of the mesentery to the wall of the intestine which was stretched around its periphery. The mesenteric mass was multinodular, firm, boggy, white with yellow and orange areas, and varied in width from 2 to 6 cm. A frozen section biopsy was reported as benign. Milky fluid oozed from the mesentery at the biopsy site. Resection of the deformed mesentery with 65 cm. of jejunum was carried out (Fig. 1). Microscopic sections showed a proliferation

of lymphatics, many of them cystically dilated without proliferation of the lining endothelium. In the surrounding edematous stroma there were lymphocytes and lymphoid follicles with germinal centers. In many of the cysts chylous fluid was seen (Fig. 2A & B).

The infant has subsequently done well after a transient period of diarrhea. When last seen at the age of two years and three months, he was healthy, eating a regular diet, and having about two normal stools daily.

Discussion

Mesenteric lymphangiomas are only occasionally mentioned as the cause of abdominal tumors in infancy and when reported are usually single case reports.¹⁻³ Hydronephrotic and cystic kidneys, hydrometrocolpos, ovarian tumors, neuroblastomas, Wilms' tumor and liver tumors are the usual causes of abdominal tumors in infancy. Mesenteric and omental cysts are less frequently encountered. Lee et al,⁴ in 1955, reported 67 cases of large abdominal tumors in childhood. Two of their cases were mesenteric lymphangiomas. Longino and Martin⁵ in 1957 reported 32 abdominal masses in the newborn, one of which was a mesenteric cyst. In Gross' Textbook of Surgery in Infancy and Childhood,⁶ he reported six omental cysts and 13 mesenteric cysts. Six of the mesenteric cysts involved the jejunum, five the ileum, one the transverse colon, and one the sigmoid colon. Five of his patients had chylous ascites and eight had serous ascites. He stated that isolated mesenteric cysts had an excellent prognosis, but widespread lymphangiomas of the mesentery were extremely difficult to manage and occasionally impossible to completely remove. Several of his patients developed recurrent intestinal obstruction. There were three deaths. Fortunately, in the case reported here, it was possible to remove most of the lymphangioma except at the very root of the mesentery where some tumor had to be left behind for fear of damaging the superior mesenteric vessels.

From Wuesthoff Memorial Hospital, Rockledge.

Presented before the Pediatric Surgical Sectional Meeting, 102nd Annual Meeting, Florida Medical Association, Hollywood, May 8, 1976.



Fig. 1.—Resected mesenteric lymphangioma. Adjacent jejunum has been opened along the antimesenteric border.

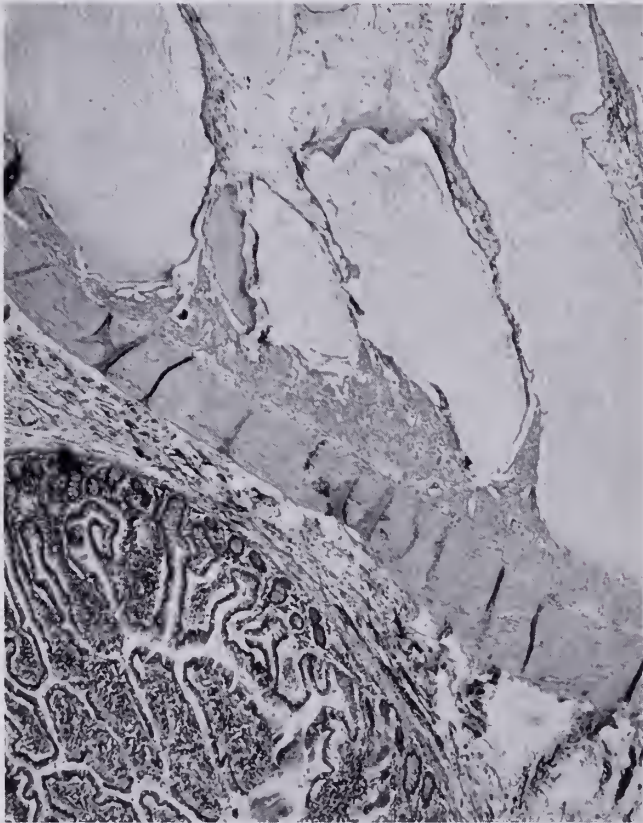


Fig 2.—(A) Photomicrograph of cystic lymphangioma arising in the mesentery adjacent to resected jejunum.

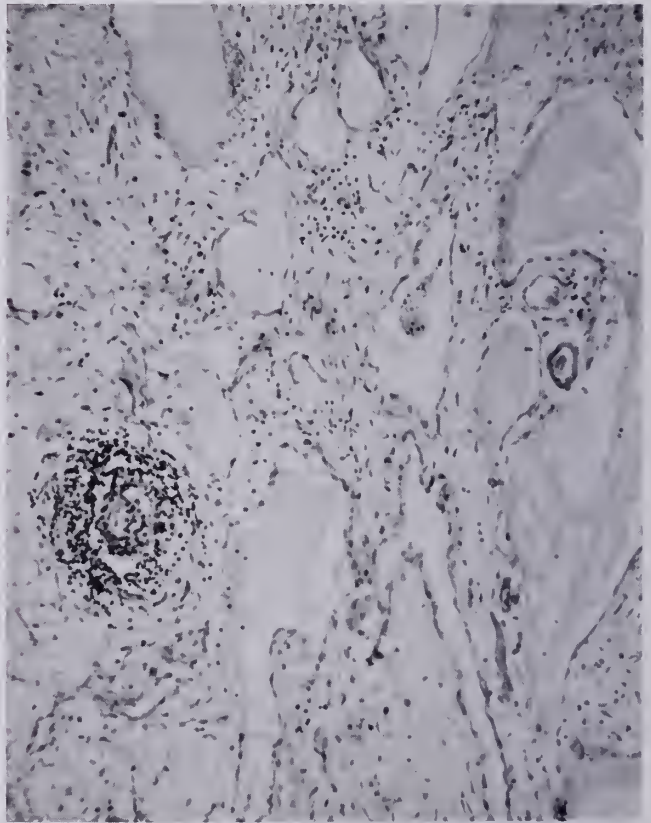


Fig. 2.—(B) Photomicrograph showing cystic areas filled with chyle and lymphoid follicle.

Intestinal lymphangiectasia is a condition that may be confused with mesenteric lymphangioma. Infants with intestinal lymphangiectasia have abdominal distension with chylous ascites, peripheral edema, and steatorrhea.⁷ The diagnosis is suggested by finding chyle on abdominal paracentesis and confirmed by biopsy of the small intestine which shows dilated lacteals in the mucosa and submucosa with distortion of the villous architecture. The mesentery is normal. These infants have a protein-losing enteropathy resulting in an immune deficiency with leukopenia. The condition in the intestine is too diffuse to lend itself to surgical therapy. Treatment consists of dietary management with a formula containing medium-chained triglycerides since these are transported by venules instead of lymphatics. Later a high protein, low fat diet can be given.

The intermittent nature of this infant's symptoms can be explained by the amount of chyle trapped in the mesentery. When eating a regular

diet, the mesentery would distend with chyle and the infant would become ill. However, when drinking only clear liquids, the chyle dissipated allowing the symptoms to subside only to recur when a regular diet was resumed.

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Dr. Jensen, 1785 Rockledge Drive, Rockledge 32955.

A NEW TUMOR OF THE TESTIS

Philip Hinton, M.D. (by invitation), H Warner Webb, M.D., Albert H. Wilkinson Jr., M.D. and Burton H. Harris, M.D.

Newborn examination of a 3200 gram white male was normal except for a swollen left scrotum. The testis was enlarged, hard and moveable, and the contralateral testis was normal. A diagnosis of antenatal torsion of the testis was made.

The scrotum was explored through an incision in the midline raphe. A strange looking, large, unfixed "testis" was delivered. It was firm and polycystic, the cysts containing clear brown and yellow fluid. A vascular clamp was immediately placed across the vas and vessels and the tumor removed. Frozen section diagnosis was inconclusive and a high radical orchiectomy was completed. Exploration of the contralateral testis disclosed a bellclapper deformity, but the gonad was otherwise normal and no biopsy was done.

Permanent sections showed a polycystic tumor confined to the testis and replacing most of the testicular parenchyma. The cyst walls contained cells which closely resembled the granulosa cells of ovar-

ian follicles. After much deliberation, the tumor has been designated a gonadal stromal tumor, granulosa cell type, probably benign. The patient did not receive either radiotherapy or chemotherapy and is now two years old with no evidence of recurrence. He has a normal karyotype, normal intravenous pyelogram, and no sign of unusual hormone activity.

The seven week embryo has an organized but indifferent gonad which evolves into either testis or ovary. Our patient's tumor has male germ cells with a female stroma. No similar lesion has been reported. Surgeons should be alert to the unique problems which may be found during exploration of scrotal masses in the newborn. Radical surgery before study of the permanent sections is inappropriate.

From the Department of Surgery, Jacksonville Children's Hospital and the University of Florida College of Medicine (JHEP), Jacksonville.

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SPECIAL ARTICLE

Psychiatric Consultation For a Jail in Trouble

Ernest C. Miller, M.D., Julla Floyd Gehan, M.A., James L. Mathas, M.A.,
James L. Nevlin Jr., B.S.W. and Eduardo R. Paat, M.S.

Abstract: The Jacksonville Detention Facility was successfully sued in Federal Court by inmates for alleged inadequacies in the level of mental health services provided them. To afford the Court a scientific basis for its recommendations, psychiatric consultation was obtained and a four part study which followed revealed: 67 percent of the inmates to suffer some degree of psychiatric disturbance; correctional officers to be insensitive to prisoners' emotional infirmities and unacquainted with extant treatment resources for prisoners; prisoners to be disproportionately young and black compared with the general population of the city; the city populace to be empathic and inclined toward financial support of improved mental health care of prisoners.

A unique opportunity in program consultation was presented the Community Mental Health Center of University Hospital of Jacksonville eventuating from a class action suit filed in the Federal Middle District Court of Florida. In the suit, inmates of the Jacksonville jail faulted the jail administration on many issues, one of these an alleged failure to provide adequate mental health services. Unrestrained by the judiciary's traditional "hands off"¹ policy with respect to jail administrative matters, the Honorable Charles R.

Scott instructed that the sheriff obtain the services of a psychiatric consultant "whose report shall be submitted to this Court regarding implementation of a mental health program from the Duval County Jail." Pogrebin² ably articulates the rationale of such an order:

"Those inmates who are willing to receive psychiatric treatment also deserve the protection of the rights suggested in the Universal Declaration and guaranteed by the Federal Constitution."

The Duval County Jail, a twenty year old structure, serves the over 600,000 population of Jacksonville, Florida, as a detaining facility for individuals recently arrested, awaiting bonding or arraignment, and convicted of misdemeanors. Prior to the Court's injunction of July, 1975, the usual jail census of 575 inmates was about one-third over the designed capacity of the jail. Medical ministrations were provided by a part-time physician and a small staff of nurses. Some psychiatric service was already furnished by a Field Services Team from the Community Mental Health Center who would visit the jail once weekly. Through the months that followed the Court's injunction, correction of many other jail discrepancies cited in the Judge's Order was undertaken by the jail's officialdom. The psychiatric consultation was instigated on request

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from the jail chief and was one of the last of the Court's orders to be implemented.

Procedure

A bibliographic search failed to yield a specific precedent upon which the consultative approach could be modeled. Indeed, a number of earlier studies^{3 4 5 6} did suggest that a high percentage of prison inmates suffered categorical psychiatric illness. Undercover agents have been used to evaluate prisoner conditions from within⁷ and two recent papers^{8 9} interestingly investigated the specific problems faced by correctional officers in the prison institution. Telephone calls to a number of cities in Florida and adjacent states found their jails, with one exception, to be no better off than Jacksonville's with respect to mental treatment availability.

A four dimensional approach was finally elected by the consultant team as the method most likely to yield meaningful data. An assessment of the psychological characteristics of the jail inmates seemed to be the logical starting point. A measurement of the "mental health quotient" (attitudes and awareness, training with respect to mental health problems) of the correctional officers' subculture was next deemed essential. Finding themselves between the factions of management and inmate, the correctional officer is in an unenviable and stressful role. These are the persons who work most closely with the inmate population and they could potentially be the weakest link in any system of mental health services which could be obtained as a result of this consultative work. Studies on public opinion regarding criminals and the criminal justice system are not new¹⁰ but the team was convinced that successful implementation of any recommendations could not be obtained without support of the local taxpayer who must ultimately bear the cost. In view of this, a poll was designed to measure the attitude of Jacksonville citizens toward prisoners and local prison facilities. To round out the assessment, socioeconomic data was collected on the inmates, partly to provide a cross-validation on the psychological testing and partly to enable the consultants to conceptualize the modal inmate.

Psychological Assessment of Inmates

To yield a reliable and valid study and minimize the sampling error and/or bias, 104 of the estimated 400 inmates were picked as subjects by random sampling. All males, they ranged in age from 18 to

75, with the largest percentile being the 21 to 24 year old age group.

The MMPI was chosen as the screening parameter for several reasons: it provides an individual personality profile; it is geared to be given in a group situation; it measures ten different personality characteristics or variables, and has validity scales designed to weed out possibilities of faking or random answering of questions without comprehending its contents. The MMPI is not without major drawbacks. As Graham and Taylor¹¹ have suggested, the MMPI's vocabulary is difficult. The complex structure of the questions is often confusing for subjects of limited intelligence and for those who lack formal education. The authors, further citing the work of Dahlstrom, Welsh, and Dahlstrom,¹² have postulated that subjects with less than six years of successful schooling may have difficulty finishing the test satisfactorily. Thumin¹³ has suggested that despite the number of investigators addressing themselves to finding relationships between MMPI responses and the age, education, and intelligence of subjects, the amount of data is too limited to draw either cogent conclusions or firm generalizations regarding the interaction of these variables. A review of the demographic data on the inmates revealed that approximately 75% of them had achieved a ninth grade level of education. The median grade achieved was eleventh, with 43% having completed high school.

Although the MMPI was shortened in the number of questions from 566 to 396, this does not affect the outcome of the profiles.¹⁴ Those questions that were left out are "fill-in items" and did not come into play in the computation of raw scores.

Method of Validation: To insure reliability of the MMPI profile and read-out, cross-validation was secured through psychosocial and psychiatric evaluations. Those subjects with valid profiles, who were tapped as manifesting debilitating emotional symptomatology, according to Marks and Seeman,¹⁵ were referred for further work-up to the Community Mental Health Center's psychiatric social workers and psychiatrists. (Cross-validation might have proceeded more consistently had other psychologists, familiar with the test, been utilized for this purpose). Those subjects with invalid profiles (defining invalid as the difference between F and K raw scores as positive nine or more),¹⁶ were also referred to social workers and ultimately to psychiatrists for evaluations to determine the reason(s) for the invalid profile. A check of those invalid profiles revealed a positive difference of 19.8 between the F and K scales. It is conceivable that

invalid profiles could also be generated by alcoholic subjects with recent toxic exposure as suggested by Libb and Taulbee,¹⁷ with transitory elevation probably on scales 6, 7, 8, or 9 reflecting confusion and mental disorganization or disorientation. Such manifestations, however, would likely not have gone unnoticed by the investigators, especially with the tester-subject relationship being one to one.

Results and Discussion

The MMPI profiles of the 104 inmates fell into several categories, as seen in Table 1. For the purposes of this study, a neurotic profile was determined by the elevations on scales 1, 2, and 3, referred to as the neurotic triad. This is contrasted with the more severe pathology resulting in impaired mental functioning, interfering with the capacity to meet the ordinary demands of life, labeled as "Identified Significant Psychiatric Cases." These latter profiles were determined by elevations on scales 6, 7, 8, and 9, while character disorder classification was the result of the inmates producing elevations on scales 4 and 9.

The profile read-outs of the 24 Identified Significant Psychiatric Cases were documented by the evaluation of the psychiatric social workers. Both are in agreement that all were felt to have unconventional thought patterns, obsessions, resentfulness, attitudes of suspicion toward other people, ideas of reference, and feelings of unreality or emotional alienation. In fact, some of these subjects identified through psychological assessment as having significant psychiatric disorders were already being seen in psychotherapy by the Field Services Team prior to being selected as sample.

Twenty-four profiles were considered to be invalid and were seen for differential evaluation by social workers and psychiatrists. All of these individuals were felt to represent characterologic disorders and the invalid profiles to be the result of lack of motivation or actual non-cooperation. With this finding, the number of cases tapped as character disorder was increased from 16 to 40, or 39%. (Table I)

It was felt that the categories of Neurotic, Significant Psychiatric Disorder, and Character Disorder constituted persons in need of mental health care. This being the case, 70 of the sample of 104, or 67%, are identified as needing mental health care. If these figures can be extrapolated to the jail population as a whole, then 67% or approximately 268 inmates would be in need of mental health services of some type.

Although there are 70 inmates out of 104 (67%) identified as having psychiatric disorders, it may not be

realistic or accurate to represent this as the number of psychiatric cases that actually exist in the city jail.

Two important intervening variables could conceivably increase the actual number of psychiatric cases. One, this study was not able to clinically probe those individuals who did not finish the assessment and those who did complete the assessment, but failed to identify themselves. Two, although it is known that the average length of stay of inmates is about a week, the jail's rate of admission and release is not known and the number of mentally ill inmates may vary in proportion to the rate of admission and release.

Interview With Jail Personnel

Correctional officers and nurses at the jail were subjected to questionnaires, individual interviews, and a rap group, designed to answer the following questions: (1) Who should provide care? (2) How much care is needed? (3) What are the general attitudes of these personnel toward current mental health care? and (4) What can be done to improve care? The questionnaire directed toward the correctional officers was longer and not as psychiatrically oriented as the nurses' questionnaire and was attitudinal in nature, asking the above stated questions in a covert manner.

A total of 93 questionnaires from the correctional officers and 8 from the nurses was returned to the survey team. These provided a sample large enough to produce a clear picture of the general attitudes of said personnel concerning the mental health of those incarcerated at the Duval County Jail.

The correctional officers felt that more professionally trained personnel were needed at the

TABLE I

CATEGORIES	TOTAL CASES	PERCENTAGES
Neurotic	6	6%
Identified Significant Psychiatric Cases	24	23%
Identified Character Disorder	16	15%
Non-Psychiatric Cases	18	17%
Invalid	24	23%
Incomplete	16	16%
TOTAL	104	100%

jail and that the mentally ill inmates needed to be separated from the other inmates.

It was also obvious on the basis of the assessment that the personnel at the County Jail lacked knowledge concerning the present mental health care already being offered to inmates, the consultants thus assuming that the inmates were also uninformed. It also became obvious that jail personnel were unable to recognize mentally ill inmates and would thus be hampered in the referral process, even if they were aware of the available treatment resources.

It was further discerned that there was feeling among the jail personnel of a lack of follow-through and coordination of a treatment program with respect to problem inmates, even when their problems had been identified.

Telephone Survey

The telephone survey was designed to reach 500 city residents. The sample population was taken from a random number selection from the City Exchange Directory, with a representative percentage of each exchange in proportion to the total number of phones listed. Contacts were made over a two week period by volunteers from various public sources, i.e. a home for the retired, students from a university, and a mental health center. Calls were made from 7:30-9:30 PM to increase the probability of a balanced heterogeneous sampling. Sample size and proportionate representative phone exchanges were designed to increase the validity of the study.

Opinions and other pertinent data, i.e. age, sex, and the comprehension of the questions by the residents, were obtained via the questionnaire. Seven questions were presented. Three were multiple choice, two required yes or no responses, and two were nonstructured, i.e. "Is there anything else about the jail that you would like to tell us?" designed to elicit more open or free responses than the structured questions would bring.

Internal consistency was designed into the instrument. For example, if a respondent answered the question, "What do you think is the cause for criminal behavior?" with "Learned to be bad," it would be expected that the respondent would not select the multiple choice answer, "None," to the question, "How many of the 400 prisoners in the County Jail are mentally sick?" The Chi-square Test was employed for the measurement and analysis of the general data and also for tests of internal consistency. A comparison of the responses to each

question with those of each of the other questions produced 52 matrices of cells which were examined for consistency. The results of the Chi-square Test strengthened the statistical argument supporting the validity of the findings. Only data yielding $p < 0.05-0.01$ were considered worthy of discussion and implications of predictability.

The results of the survey are based on a high percentage (81%), 408 of the initial goal of 500 residents. The sample population was comprised of 256 females (64%) and 131 males (31%). The conspicuous age representation for both sexes was 30-50. The gender of 5% of the sample was not reported.

Based on the study, the residents of Jacksonville estimate that there are from one-quarter to one-half of the four hundred of the jail's inmates to be suffering from some form of mental illness. Residents also indicate a humanitarian and empathic concern for prisoners in that they should either be sent to prison and treated or sent to a state mental hospital for treatment. Many residents show a preference for keeping prisoners in the community while undergoing treatment for their illness.

The study further predicted that the majority of citizens would support reasonable taxation for the improvement of facilities and for adequately trained human health-care professionals to treat the prisoners. They will probably support reasonable salary increase for training and upgrading correctional officers, which would underwrite the provision for mental health care, general physical treatment and humanitarian attitudes toward the inmates. The general findings of the study suggested that residents of the city were aware of human health needs of prisoners and are in favor of legislation which will provide better physical and mental health care and treatment for the prisoners and would support measures that are necessary to insure an environment that is just and humanitarian for prisoners.

Demographic Characteristics of Inmates

A questionnaire especially designed to extract socioeconomic and amnesic data was administered to 98 inmates in the late afternoon or early evening of the day they took the MMPI. Twenty questionnaires were removed from the sample because there were no valid MMPI's on those inmates. The final sample size was 78 inmates. The inmates were disproportionately young and black. Whereas in Jacksonville as a whole only one-fourth

of the male population is between 18 and 25, 50% of the inmates are between 18 and 25. In Jacksonville, 23% of the population is black; in our sample, as in the jail as a whole, 50% were white and 49% were black.

All of the inmates are United States citizens. Forty percent of those old enough to have been drafted had served in the armed forces. Ninety percent of those who served were honorably discharged. Twenty-four percent were commended for bravery, Twenty-four percent served in combat in Viet Nam. The majority of the inmates are Protestant; 14% are Roman Catholic and 5% have no religion. Academically, the inmates are poorly educated. The median grade achieved was the eleventh grade, and 43% have high school diplomas or equivalents. The inmates are poorly trained: 52% are unskilled laborers, 40% are skilled laborers, and 6.6% are white collar workers. They are chronically unemployed, especially the blacks. Fifty-eight percent of the inmates were unemployed when they were arrested and 39% had been out of work for more than two months. Seventy-one percent of the blacks were unemployed when they were arrested and 53% had been unemployed for over two months. Fifty percent made less than \$5,000 last year. The highest reported income was \$20,000. (The income question was the only one that was not answered by at least 86% of the inmates.)

The data indicated that, contrary to our expectations, many of the inmates come from conventional living situations. Though only one inmate rated his neighborhood as "well off" (incomes above \$20,000), 62% felt that their neighborhoods were either "doing OK" or "getting by" (\$7,000 to \$10,000). Only 35% felt that their neighborhoods were poor, out of work, or were transients. Though the inmates are mobile within Jacksonville (79% moved within the last year), the majority of the inmates are permanent residents of Jacksonville. Fifty percent of the inmates have lived in Jacksonville over twenty years. Only 19% have moved to Jacksonville within the last year. Fifty-five percent of the inmates were living with their families when they were arrested. Forty-five percent of the inmates had never been married. Thirty-two percent were married and living with their wives and 23% were separated or divorced. Fifty-three percent of the inmates have children; however, only 27% of the inmates were living with their children at the time of the arrest.

Amnestically, 45% of the inmates were reared in a nuclear family setting and 14% more were reared in extended families. Eighteen percent were reared

in female-headed households. Twenty-eight percent were shuttled back and forth between family members and/or institutions. Thirty-four percent of the blacks were reared in a matrifocal family. What is even more significant from an amnesic point of view is that at least 50% of the inmates came from families where at least one member had a drinking problem or an emotional problem. The inmates reported family members with the following problems: alcohol - 50%; street-drug abuse - 26%; and emotional problems - 53%. Of those family members who had emotional problems 40% were anxious and "nervous;" 18% were "sad and crying all the time," 18% were "very sad sometimes" and "very happy" at other times; 5% were mute and staring into space; 8% thought "everyone was out to get him;" and 8% "saw or heard things that were not there." Many of the inmates indicated problems in their school environment: 18% were in special classes; 32% had problems learning to read; 30% had problems in paying attention; 56% had had problems with school and/or legal authorities as a child.

As adults, many of the inmates reported problems related to mental health. Thirty-five percent have "seen" someone for their "nerves." Twenty-six percent have seen mental health professionals and 6% have been to state hospitals. Forty percent have wanted to "hurt" themselves and 28% have attempted suicide. In addition, many of the inmates have problems with alcohol and drug abuse. Sixty-four percent of the inmates have some problem with alcohol and 16% indicate that they drink too much, get into fights and have legal trouble after drinking, and suffer from blackouts. Thirty-nine percent have been on street drugs when arrested.

Looking at the negative amnesic factors, both in childhood and as adults, we found that 26% of the inmates had already received mental health care. In addition to these, six others had attempted suicide and three have alcohol problems. In all, thirty-five (45%) of the inmates have some identifiable need for mental health services. Of these, twenty-eight (36%) indicated that they need treatment for their "nerves." In total, 30% of the inmates have histories which indicate some mental health need and state that they would like help.

Conclusions and Recommendations

In late December, 1975, the study was completed and presented in printed form to the Administrative Officer of the Duval County Jail.

Three of the parameters yielded good consistency with respect to estimating prevalence of mental disorder in the inmate population, i.e. psychological testing, 67%; inmate amnesia, 45%; telephone poll, 50%. The attitudinal survey of correctional officers produced estimates ranging from 25% to 89%.

The team was interested to find the prevalence of psychiatric disorder in the County Jail very close to that reported in epidemiologic studies of prison populations cited earlier in this paper (see references 3, 4, 5, and 6) and indeed not unlike that reported in the general population via Mid-town¹⁸ and Sterling County¹⁹ studies. Twenty-three percent of the Detention Facility inmates suffer "significant psychiatric disorder," and an additional 44% are, in Srole's term, "less than well."

The data seemed to mandate that a psychiatric team²⁰ with a clear identity and official status be immediately established in the jail system; team composition to include a coordinator-team leader and three or four full-time core members. A nurse, resource physician, volunteer, correctional officer and others would periodically participate in the team's operation. The coordinator's function would include administrative, research, and clinical responsibilities, and participation in the policy-making within the jail administrative hierarchy itself. The telephone questionnaire unearthed no "latent retributive sentiments"²¹ among the Jacksonville respondents and was viewed as valid and consistent in reflecting a positive community attitude toward improving the jail facility. It was suggested that the results be revealed to the Finance Committee of the City Council as evidence of citizen support when the jail administration submitted its funding package for the mental health program. Other specific recommendations included the establishment of an intensive mental health orientation program for correctional officers to increase their sensitivity to prisoners' problems; the sectioning off of a Psychiatric Unit within the jail facility; the replacement of uniforms with mufti for correctional officers, beginning in the special Psychiatric Section and eventually phasing into other areas of the jail. It was also recommended that the mental health team design an inmate screening personality inventory to be administered to prisoners on their arrival, feeling that this would be of assistance in sorting out emotionally disturbed individuals and in determining the potential for violence or suicide. The development of a volunteer program to work with correctional officers and inmates in specific assignments related to social problems, educational projects, recreational interests, etc., seemed

desirable. The symbiotic advantages of developing internships in psychology, criminology, and sociology in affiliation with the several regional schools were cited. It was emphasized that the coordinator should be mandated with an ongoing evaluative responsibility, up-dating the original consultative product and periodically establishing new goals and priorities.

The desirability of establishing a research program component was posited in view of the obvious richness of the clinical and demographic material touched on by this study. The latter data alone is a treasure trove for those who might wish to demonstrate relationships of social causative factors²¹ to criminal behavior, and some of the social data, indeed, seems to substantially differ from that which was previously reported, i.e. 43% of our inmates had high school diplomas or equivalents as opposed to the 17% attainment of correctional institution inmates at large.²²

Two things have occurred subsequent to this report. A series of articles appeared in the local newspaper describing accurately and at considerable length the proceedings of the consultation and the resulting recommendations. The attorney representing the inmates responded enthusiastically and requested that all the recommendations in the consultative report be so ordered by the Court. The response of the jail administration was understandably ambivalent. To expect equal acceptance of the results by the various parties to the action is unrealistic. No matter the objective or humanitarian level of such a study, resistance is inevitable. This perhaps has to do more with the basic questions of what is criminality, why does it exist, and what can be done about it? Most persons would probably agree that despite the best efforts of therapists, criminologists, clergymen, social planners and others, that a certain number of individuals will exhibit behaviors that are not tolerable in open society. Some persons are bad, some are mad, some, most unfortunately, are both. At the present time when other resources fail, a final alternative remains, one which is best described by Scott:²³

"Some institution must always be at the end of the chain: closed approved schools, closed Borstals, prisons, and special hospitals. Society and all the open institutions owe a debt of gratitude to these last links, which absorb their most difficult members."

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1975 Florida Relative Value Studies

Please make the following changes in your 1975 Relative Value Studies.

1. On page 54 the unit value for procedure No. 11770 and procedure No. 11771 were reversed. The unit value for No. 11770 should be 1.8 and the unit value for procedure No. 11771 should be 4.6.
2. On page 54, the parenthetical comments after procedure No. 11772 should refer to procedure 13100-15738 not 13000 to 15738 since no 13000 exists.
3. On page 55 there is a reference to a Modifier 28. This is a typesetting error; there should be no reference.
4. On page 88, the parenthetical comment above procedure No. 31245 should refer to code No. 61548 instead of 61665.

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ORGANIZATION

More Scientific Programs Announced For FMA Annual Meeting

The Scientific program for the 103rd Annual Meeting of the Florida Medical Association is nearing completion.

Details should be virtually complete some time this month, according to O. Frank Agee, M.D., of Gainesville, General Program Chairman. The Convention will be held at the Americana Hotel in Bal Harbour, May 4-8, 1977.

The program has been approved for 20 hours of AMA Category 1 credit, and an application for an appropriate amount of Prescribed credit is being processed by the American Academy of Family Physicians.

Latest program information includes (see November and December 1976 issues of **The Journal** for other details):

FRIDAY AFTERNOON—MAY 6

SECTION ON RADIO THERAPY SECTION I

(Co-sponsored by Florida Radiological Society)

Friday—2:00 p.m. to 5:00 p.m.

Phillip C. Smith, M.D., Gainesville
Program Chairman

Opening Remarks and Welcome - Herbert D. Kerman, M.D., Chairman, Radiotherapy Section, Florida Radiological Society, Daytona Beach

"Curative Radiation for Unusual Tumors - Chemodectoma, Optic Glioma and Craniopharyngioma," Robert G. Parker, M.D., Immediate Past President, American Society of Therapeutic Radiologists, and Professor of Radiotherapy, University of Washington School of Medicine, Seattle, Washington

Selected Papers to be Announced

Adjournment

SECTION ON PEDIATRICS

(Co-sponsored by Florida Chapter, American Academy of Pediatrics, and Florida Pediatric Society)

Friday—2:00 p.m. to 5:30 p.m.

James A. Hallock, M.D., Tampa
Program Chairman

"Echocardiography" (Speaker to be Announced)

"Approach to the Newborn with Heart Disease" (Speaker to be Announced)

Break

"Rheumatic Fever" (Speaker to be Announced)

"Hypertension" (Speaker to be Announced)

Discussion

Adjournment

SATURDAY MORNING—MAY 7

SECTION ON ALLERGY AND IMMUNOLOGY (Co-sponsored by Florida Allergy Society)

Saturday—8:00 a.m. to 12:30 p.m.

Roger J. Zwemer, M.D., Vero Beach
Program Chairman

"Theoretical Basis of Current Pharmacological Approaches in the Treatment of Asthma," Andor Szentivanyi, M.D., Professor and Chairman, Department of Pharmacology, University of South Florida College of Medicine, Tampa

"A Critical Review of Current Drug Therapy for Asthma," Elliot Ellis, M.D., Professor and Chairman, Department of Pediatrics, State University of New York at Buffalo School of Medicine, Buffalo, New York

Coffee Break

"Chronic Urticaria and Angioedema," Jose M. Quintero, M.D., Coral Gables

"The Role of Infection in Asthma," Elliot Ellis, M.D., Professor and Chairman, Department of Pediatrics, State University of New York at Buffalo School of Medicine, Buffalo, New York
Adjournment

SECTION ON RADIOTHERAPY

SECTION II

(Co-sponsored by Florida Radiological Society)

Saturday—9:00 a.m. to 10:15 a.m.

Phillip C. Smith, M.D., Gainesville
Program Chairman

"Effects of Adjunctive Chemotherapy on Normal Tissue Response and Complications in Radiotherapy Patients," Robert G. Parker, M.D., Immediate Past President, American Society of Therapeutic Radiologists, and Professor of Radiotherapy, University of Washington School of Medicine, Seattle, Washington

"Carcinoma of the Base of the Tongue," Rodney R. Million, M.D., Professor and Chairman, Division of Radiotherapy, and Ed. C. Wright Professor in Clinical Oncology, University of Florida College of Medicine, Gainesville

Adjournment

SECTION ON SURGERY

(Co-sponsored by Florida Chapter, American College of Surgeons, and Florida Association of General Surgeons)

Saturday—9:00 a.m. to 12:00 noon

John C. Fletcher, M.D., Tampa
Program Chairman

Panel Discussion to be Announced

"Hyperalimentation - Update," Stanley J. Durick, M.D., Professor and Chairman, Department of Surgery, University of Texas Medical School at Houston

Panel Discussion to be Announced

Adjournment

SECTION ON PHYSICAL MEDICINE AND REHABILITATION

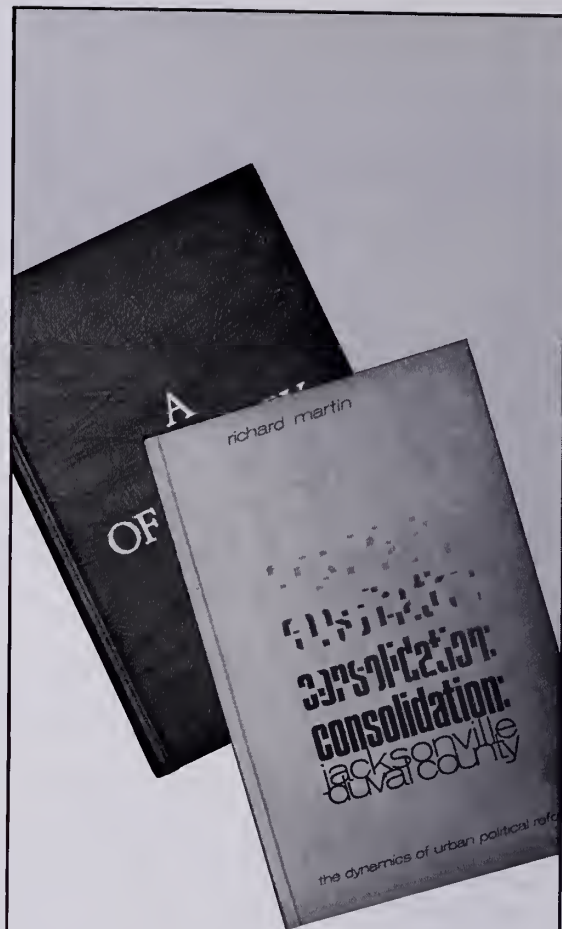
(Co-sponsored by Florida Society of Physical Medicine and Rehabilitation)

Saturday—10:30 a.m. to 12:00 noon

Charles J. Kurth, M.D., Orlando
Program Chairman

"Acute Care of the Spinal Cord Injured Patient," Barth A. Green, M.D., Chief, Acute Spinal Cord Injury Service, and Assistant Professor of Neurological Surgery, Orthopedics and Rehabilitation, University of Miami School of Medicine, Miami

Adjournment



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Report of FMA Delegates to AMA

"National Health Insurance"

AMA Clinical Meeting

Philadelphia, December 4-8, 1976

The Florida delegation to the AMA was a conscientious group, as usual, at the AMA meeting in Philadelphia. We met in caucus on four occasions totaling about 10 hours. We had a Florida representative for the entire session of every reference committee and Dr. Charles K. Donegan served on a reference committee. All seven Florida seats were filled at all times at all House of Delegate meetings . . . about 17 hours in all.

The most important and the most time consuming item of business involved "National Health Insurance." We were instructed by the FMA House of Delegates to oppose all forms of NHI except catastrophic. The Florida resolution to this effect was referred to the Board of Trustees at the June meeting in Dallas. The big question in Philadelphia was whether the AMA should sponsor a bill similar to HR 6222 (Comprehensive Insurance Act of 1975) in the next Congress. We worked hard in opposition to this; Dr. Joe Von Thron made an excellent presentation to the House on the subject. The Florida delegation voted unanimously against HR 6222, but we did not prevail . . . I believe the vote was 181 to 57, with us on the losing side.

I find it difficult to impugn the motives of those

on the prevailing side. I would guess that at least 80% of the delegates are against a National Health scheme . . . the entire thrust of the argument was how best to prevent it, or to modify it so as to be at all palatable. Staunch long-time opponents of Socialized Medicine conscientiously believe our best approach is to present a viable bill of our own. We can only hope their reasoning is as good or better than ours.

Our delegation intervened in two other relatively minor issues, and on these the House of Delegates supported Florida's stand.

As I said initially, our delegates worked hard; so did our alternate delegates, all of whom attended. We are represented on the Board of Trustees by Dr. Jere W. Annis, Vice-Chairman, and Dr. Frank Holland, Vice-President of AMA. Dr. Burns Dobbins is on the Judicial Council; Dr. Richard Connor on the Council on Education. Florida exerts a considerable influence in the deliberations of AMA.

James T. Cook, M.D., Chairman
Florida AMA Delegates
Marianna

“Know Thy Work And Do It”

If, in 1976, you did not do what you were best equipped to do . . . if you did not do well what you had undertaken as your personal contribution to the world's work . . . or if you did not find happiness in your work . . . If these “if's” are true of you, then not only you but the world as well is the loser. An economic system exists to improve the quality of life of the people living under it, thus mandating that each member's productivity increase according to the system's need. To make this globe a better place on which to live, we must work to improve our skills, our purposes and our integrity. Although physical growth stops at a certain time, this is not true of knowledge, of the mind, or the spark of creativity.

In the New Year, as was in 1976, time is the most precious commodity, the inexplicable raw material of everything produced and when budgeted wisely by self discipline, allows us to spin out health, pleasure, money, content, respect and the evolution of one's immortal soul.

There is no higher pleasure in life than that of surmounting difficulties, forming new wishes and seeing them gratified, to labor in any undertaking, strive with difficulties and conquer them. The dividing line between failure and success is a narrow one, so fine that a little more persistence, a little more effort often turns what seemed like hopeless failure into success. Among the philosophers, there is no failure except in no longer trying, and they say, “A man might strive all his life faithfully and singly toward an object and not obtain it, yet if he constantly aspires, is he not elevated?” Forget your limitations, do the best you can with what you have, make the most of your opportunities and abilities and fulfill the promise that lies within you. The most important thing about a New Year is that as long as we are alive, we have the privilege of developing unexercised talents, engaging in

beneficial kinds of work, devoting ourselves to new causes and making new friends. So, daily exercise initiative and refuse to become fixed or rigid. Remember that all men are capable in some directions and limited in others but that all can contribute from the storehouse of their skills to the enrichment of their community, their profession and their common life.

In 1977, one will get out of the New Year just what one puts into it. With 365 fresh starts from which to choose, of all the elements necessary for success, there is no handicap or obstacle that cannot be overcome by willpower, patience and application. The New Year provides time to take advantage of a virtue that lies in all men and that is the ability to correct mistakes and start over. Greatness does not depend on fortune but rather on the value we insensibly set upon ourselves that destines us for the things we accomplish. A man's life and character are the results of his innermost thoughts affecting even his disposition, for the soul is tinged with the color and complexion of its own thoughts. Just as a gardener cultivates his plot of ground, so may a man tend the garden of his mind, weeding out untruths, weaknesses, and prejudices against his fellowmen while cultivating toward perfection the flowers and fruits of confidence, diligence and new ideas. Sooner or later, one will discover that he is master gardener of his own soul, yet so long as he believes himself a creature of outside conditions, he will be buffeted by circumstances. In all human affairs, there are efforts and there are results and the strength of effort is the measure of the result. Aspirations, intellectual and spiritual possessions are the fruits of effort. They are thoughts completed, objectives accomplished, and visions realized. Good thoughts bear good fruit. As thoughts and character are one, the higher a man

lifts his thoughts, the greater his achievement. Cherish dreams and ideals, setting new goals at the start of each day. Keep them constantly in mind, for "As a man thinketh in his heart, so is he."

Success is the achievement of self respect by doing one's best with what one has to work, remembering that life's highest aim is keeping one's soul aloft.

C.M.C.

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Commentary

1977 — Another Beginning

Richard C. Dever, M.D.

In January of 1977 Blue Shield of Florida plans to implement the Advanced Medicare System of EDSF Corporation for the processing of Medicare claims in those areas of the state where it is Part B intermediary. For the physician, the most advantageous of the many improvements this new system will bring is the ability of our claims examiners to be on-line with the computer and to edit or correct the claim at the front end and then enter it directly into the system where the computer will process it for payment in real time. For this reason, we expect an improvement in both the cycle time for claims and in the accuracy of reimbursement when this system is activated and automated claims processing begins in early 1977.

This system, as are all computer systems, is completely dependent on the accuracy of the material put into it. Here, the practicing physician in Florida has a choice to make.

Firstly, the physician can submit a 1490 form, properly itemizing and coding his services to his patient, so that his customary fee is truly determined by the charges he submits. Even if not using the 1490 form, he can, with Blue Shield's help, insure that his billing forms, receipts, ledger cards or whatever system he uses, list an accurate precoded description of the services he provides to his patients. Only then can he be confident that our files accurately reflect his charges.

Or, secondarily, he is at perfect liberty not to submit a 1490 claim form for his patients and instead

to provide his patient with a variety of bills, receipts, ledger card copies and other pieces of paper, letting his patient attempt to get all of this material handled by the system. As well, he can elect not to precode his services and, in effect, not to describe them by the Florida Medical Association's own 5-digit coding system as set forth in the 1975 Florida Medical Association Relative Value Studies Manual and in the Blue Shield Manual for Physicians. In each of these situations he has delegated to his patients or to his office personnel the determination of his charges in our charge file. Physicians who do this are among our most frequent correspondents and often the most critical of the information in our charge data files. They have, however, devoted little or no effort to insure the accuracy of our information, and they are probably unaware that their patients and employees rather than themselves are setting their levels of reimbursement and, more importantly, contributing to the construction of the community or prevailing allowance which is applied to them and to all of their colleagues in their area.

The same conditions apply to the Blue Shield Doctor's Service Report. Blue Shield has developed a new DSR based upon the AMA simplified claim form. All of the previous statements regarding physician's customary charges are equally or more applicable here. It is conceivable that the same automated claims processing technique that will be used in Medicare beginning in January, 1977 may be used for Blue Shield claims at sometime in the future if the improvements in the consistency, accuracy, and timeliness of payment expected are in truth achieved with the cooperation of Florida's practicing physicians.

Dr. Dever is Vice President and Medical Director, Blue Shield of Florida, Jacksonville.

The choice is quite simply up to Florida's doctors. Blue Shield already puts its resources forward on behalf of the physician by providing Doctor Service Reports and pre-printed SSA Form 1490's upon your request to the Physician's Services Department or the Physician Relations Representative in your area. Your employees are invited to take advantage of the workshops held over the state to assist them in coding and other facets of claims preparation. The Medical Division of Blue Shield of Florida similarly stands ready to assist in any way possible should you have questions about the use of codes or require confirmation of the coding information that you presently use. Florida's physicians are continually striving on behalf of their patients health and Blue Shield hopes that they will be willing to strive equally as much on their own behalf to provide accurate data from which their own or their patient's proper reimbursement can be determined under our private programs as well as Medicare.

- Dr. Dever, P.O. Box 1798, Jacksonville 32201.

INFECTIOUS DISEASES 1977—TREATMENT AND PREVENTION

March 3 and 4, 1977.

Guest Faculty:

MERLE SANDE, M.D., Charlottesville, Va.;
 PHILLIP LERNER, M.D., Cleveland, O.;
 THOMAS HOFFMAN, M.D., Miami, Fl.;
 ROBERT REIS, M.D., Miami, Fl.

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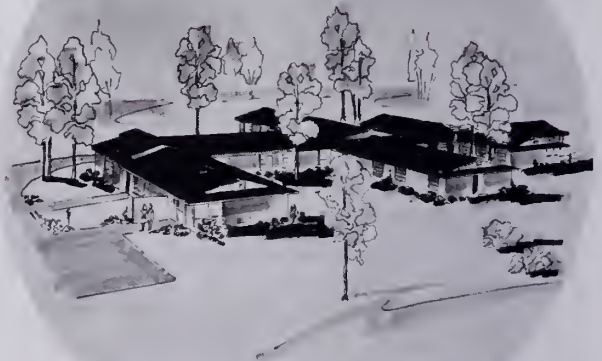
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ACCREDITED BY THE J. C. A. H.

Medical News Around the State

Louis C. Murray, M.D., of Orlando . . . President-Elect of the Florida Medical Association, has been cited as a Distinguished Alumnus of the University of Florida.

Alfred C. Warrington, President of the University Alumni Association, conferred the award during commencement ceremonies on December 11 in Gainesville. Dr. Murray received a Master of Science degree at Florida in 1948.

Formerly a member of the Florida Board of Regents, Dr. Murray currently is Chairman of the Medical Advisory Committee to the University of Florida College of Medicine.



James M. Ingram, M.D., of Tampa . . . has received a Distinguished Alumnus Award from Duke University College of Medicine.

Dr. Ingram is Professor and Chairman of the Department of Obstetrics and Gynecology at the University of South Florida College of Medicine in Tampa. He received the award at the Duke Medical Alumni Awards Banquet at Durham, N.C., on October 29.

The American College of Cardiology . . . has admitted 10 Florida physicians to Fellowship in the organization.

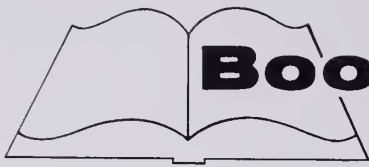
According to **Henry R. Cooper, M.D., of Ft. Lauderdale**, ACC Governor for Florida, the following physicians were among 151 doctors from the United States and Canada to be admitted to the College's highest membership classification:

Robert A. Buccino, M.D., Lakeland; Abraham Caplivski, M.D., and Saul J. Dobrlnsky, M.D., Lauderdale Lakes; **R. C. Curry Jr., M.D.,** Gainesville; **Richard H. Davls, M.D.,** Fort Myers; **Benet S. Kolman, M.D.,** Hollywood; **George M. Mathews, M.D.,** Leesburg; **Carroll L. Moody, M.D.,** Ft. Lauderdale; **Ray A. Olsson, M.D.,** Tampa, and **Richard H. Pollak, M.D.,** Miami Beach.

Sixteen Florida physicians . . . have been elected to Fellowship in the American College of Physicians.

Miami and Miami Beach placed seven physicians in Fellowship. They are: **Roy D. Altman, M.D., Jorge D. Jacobi, M.D., James R. Oster, M.D., and Nathan Segel, M.D.,** all of Miami; and **Richard A. Berger, M.D., Alan I. Braun, M.D., and Adam Wanner, M.D.,** all of Miami Beach.

Other Floridians include: **Robert J. Schwartzman, M.D.,** Coral Gables; **Edward R. Block, M.D.,** Gainesville; **Humberto Machado, M.D.,** Hialeah; **Walter E. Morris Jr., M.D.** and **Gerald N. Olsen, M.D.,** both of Jacksonville; **Robert A. Buccino, M.D.,** Lakeland; **Antonio Cahue, M.D.,** Maitland; **Neal J. Welneb, M.D.,** Tamarac; and **Charles P. Cralg, M.D.,** Tampa.



Book Reviews

Book Review Editor

F. Norman Vickers, M.D.

Review of Medical Microbiology by Ernest Jawetz, Ph.D., M.D., Joseph L. Melnick, Ph.D., and Edward A. Adelberg, Ph.D. 542 Pages. Illustrated. Price \$10.00. Lange Medical Publications, Los Altos, California, 1976.

Basic and Clinical Immunology edited by Hugh Fudenberg, M.D., Daniel P. Stites, M.D., Joseph L. Caldwell, M.D., and J. Vivian Wells, M.D. 653 Pages. Illustrated. Price \$12.50. Lange Medical Publications, Los Altos, California, 1976.

I shall review these books together because they have similar format and purpose, and the same publisher. **Bargains!** In these days of soaring prices these paperbacks, these large paperbacks, tell it like it is. Up to date, designed for student and practitioner, the information is complete, well-organized, and useful; not lab manuals, although the principles of the various tests are described in detail. Want to know how to evaluate the patient with suspected viral disease? How to get good specimens for fungus cultures? How to immunize the traveler? How to recognize Lupus? What specimens to get for confirmation of allergic disorders? How to acquire enough information to pass an exam in Bact-T or Immunology? Here are all the answers. Buy these books—you'll like them.

Courtlandt D. Berry, M.D.
Ocala

Dr. Berry is a practicing Pathologist at Marion Community Hospital, Ocala.

Job Plodd: His Trials and Tribulations by Alvan G. Foraker, M.D., F.C.A.P. Price \$17.50. Medical Economics Book Division, Westwood, New Jersey, 1975.

The story of Job Plodd is presented in a collection of satirical sketches, depicting the trials and tribulations of a pathologist in a community hospital (Podunk General Hospital). In his day to day practice, Job deals, with variable degrees of success, with the administrators (Mr. Tom Munnyfurst, Mr. I. Grabidall, etc.); the medical staff, (Dr. S. Lash, Chief of Surgery; Dr. D. Manding, Chief of Medicine; Dr. B. Button, Chief of Omphalology, etc.); the researchers (Dr. Eager and Dr. Climber); the nearby medical center staff (e.g., Dr. Greatfella of Metrocolossal University); the laboratory technical staff (e.g., Miss Suzie Exact, Chief Medical Technician; Joe Dormouse, Night Technician); the secretary (Ima Tufinger); the drug detail man (Mr. Gabb), and others.

Pathologists, who have had the "total experience" in a community hospital, will read of Job Plodd with great nostalgia. Aspiring young pathologists can gain a deep insight into human psychology, relating to their chosen field; however, the enjoyment of reading Job Plodd is not limited to pathologists. These satires touch on every specialty, and many physicians will recognize their acquaintances (if not themselves) in these sketches. Certainly, specialists in omphalology should not miss reading of themselves. You can be sure that these incidents have happened, somewhere, sometime.

In a recent communication, Frank G. Slaughter, M.D., famous physician-author, wrote: "I am reading Job Plodd: His Trials and Tribulations slowly, and enjoying every word, NO!, savoring would be the better word. It is a work of art and should be required reading in every medical school."

The book can be enjoyed best by browsing or spot-reading. The sketches span the entire career of Job Plodd and can be read in interrupted and patchy fashion without losing the sense of the content. Any physician knowledgeable and interested in hospital "goings-on" will be doing himself an injustice if he fails to browse through the chronicles of Job Plodd.

L. E. McHenry, M.D.
Melbourne

Dr. McHenry is a practicing Pathologist at Brevard Hospital, Melbourne.

Editor's Note: Dr. Foraker is well known to many Florida physicians as a respected pathologist with a well developed sense of humor and a flair for the dramatic. He has been a frequent contributor to the JFMA. See "The Romantic Necrophiliac of Key West" in the August 1976 issue of the Journal, his most recent offering for this Journal. Previously practicing in Jacksonville, he is now located in Massachusetts.

Woman, Know Thyself by Joseph W. Scott, M.D. 399 pages. Price \$12.50. Thorofare, N.J., Charles B. Slack, Inc., 1976.

The author of this book, which is designed for the patient's eye, has been a practicing gynecologist for more than a third of a century. From this experience he has developed an uncommon skill in talking with patients in terms they can easily understand. Now he has exercised that skill on the printed page and produced a book which will assist his hard-pressed colleagues—chiefly gynecologists, family physicians and internists—to provide a "full and complete disclosure" of the common problems in the field of gynecology. Written in concise, non-technical language, illustrated with lucid line drawings, and carefully indexed, it is easy to read and readily comprehensible to the lay person. Physicians who recommend it to their patients will find it a great timesaver for it answers most of the commonly asked questions related to the female genital anatomy, function and hygiene. In its pages are up-to-date discussions of such things as: menstrual problems, menopause, venereal disease, contraception, self-examination for breast cancer, surgical procedures and their complications, and many other matters.

William M. Straight, M.D.
Miami

Dr. Straight is in the private practice of Internal Medicine in Miami and is the Historical Editor of the Journal.

Books Received

Receipt of the following books is acknowledged. Medical readers interested in reviewing particular books are invited to address requests to the Book Review Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.

Solved: The Riddle of Heart Attacks by Broda O. Barnes, M.D., Ph.D. and Charlotte W. Barnes, A.M. 84 Pages. Price \$2.50. Fort Collins, Colorado, Robinson Press, Inc., 1976.

Review of Medical Pharmacology, 5th Edition by Frederick H. Meyers, M.D., Ernest Jawetz, Ph.D. and Alan Goldfien, M.D. 740 Pages. Illustrated. Price \$12.50. Los Altos, California, Lange Medical Publications, 1976.

Correlative Neuroanatomy & Functional Neurology, 16th Edition by Joseph G. Chusid, M.D. 448 Pages. Illustrated. Price \$10.00. Los Altos, California, Lange Medical Publications, 1976.

Contact Lenses and Corneal Disease by Antonio R. Gasset, M.D. 403 Pages. Illustrated. Price \$22.50. New York, Appleton-Century-Crofts, 1976.

Principles of Clinical Electrocardiography, 9th Edition by Mervin J. Goldman, M.D. 412 Pages. Illustrated. Price \$9.95. Los Altos, California, Lange Medical Publications, 1976.

Current Pediatric Diagnosis and Treatment, 4th Edition, by C. Henry Kempe, M.D., Henry K. Silver, M.D. and Donough O'Brien, M.D. 1,053 Pages. Illustrated. Price \$15.00. Los Altos, California, Lange Medical Publications, 1976.

Sleep Disturbance and Hypnotic Drug Dependence edited by Anthony D. Clift, M.D. 352 Pages. Illustrated. Price \$35.95. New York, Excerpta Medica/American Elsevier, 1975.

Nuclear Energy and National Security by the Research and Policy Committee of the Committee for Economic Development. 80 Pages. Illustrated. Price \$2.50 paperbound, \$4 hardbound. New York, Committee for Economic Development, 1976.

Clinical Methods — The History, Physical and Laboratory Examinations. Vol. 2 by H. Kenneth Walker, M.D., FACP., W. Dallas Hall, M.D., FACP., and J. Willis Hurst, M.D., FACP., FACC. Butterworths Publishers, Boston, 1976.

Coordinated Ambulatory Care, The POMR by Jefferson J. Vorzimer, M.D. 128 Pages. Price \$7.50. New York, Appleton-Century-Crofts, 1976.

The Patient's Guide to Surgery, How to Make the Best of Your Operation by Lawrence Galton. 468 Pages. Price \$10.95. New York, Hearst Books, 1976.

Current Obstetric & Gynecologic Diagnosis & Treatment by Ralph C. Benson, M.D. and Associate Authors. 912 Pages. Price \$16.00. Lange Medical Publications, Los Altos, Calif., 1976.



Others Are Saying

Medical School News . . .

The two most appropriate times for a medical Dean to address the local medical community appear to be when the Dean arrives and as he leaves.

Upon my arrival, I was indeed given the opportunity to address the HCMA. At that time the objectives to be sought for the College of Medicine were outlined. It was clear that in Tampa we were presented with an opportunity to achieve some constructive action in terms of restoration of an acceptable balance between teaching, patient care and research in the context of medical education.

The following objectives were stated as the initial and first phase targets for the development of a modern and first-rate Medical Center:

1. Admit a Charter Class no later than September, 1971.
2. Achieve full academic accreditation for both the Colleges of Medicine and Nursing.
3. To plan, finance and construct a functional and advanced facility to house the Medical Center.
4. To recruit a competent faculty with the appropriate credentials in both the basic and clinical science areas.
5. To develop an outstanding and sufficiently large house staff of American graduates to provide additional health care personnel for the community.
6. To mount and encourage a respectable medical research base which would be acceptable at the National level.
7. To implement a high-standard Ph.D. level program of graduate education in medical science, the BOR moratorium on new Ph.D. programs notwithstanding.
8. To achieve a full enrollment of students at an entering class size of 96.
9. To achieve eligibility for the installation of a chapter of Alpha Omega Alpha.

It is with pleasure that I am able to inform the Association that as I leave this office all of these objectives have been met and that the Medical Center is now poised for a second phase of development

and progress. The objectives and goals for the next step in progress towards excellence will be developed by the faculty in consultation with my successor. The fabric of the institution is now strongly woven and the necessary critical mass is present to insure continued development towards distinction.

Our success to date represents a combination of good fortune, extreme effort on the part of the faculty and considerable help by many members of the medical community. It has not always been a smooth or benign course, nothing worth doing ever proceeds without problems and tribulation. There have been disagreements, personality conflicts and other human nature types of impediments which tend to inhibit progress. Nevertheless, the goals have been met and the place in this community for Medical Education is secure.

It is my pleasure to express gratitude to all those many members of the Association who have been so helpful and supportive. Without your help, the rapid and effective development of the Medical Center would have been much more difficult and probably delayed by a considerable time.

I believe the events in the making will eliminate any possibility of a continuing collision course between organized medicine and medical education in this community. As time passes, I am sure that closer and more mutually supportive attitudes and actions will develop and bring the two groups closer together in a harmonious and productive relationship. The essential need for such relationships will, in my opinion, become clearly demonstrated in the not too distant future.

From a personal point of view, I am grateful for the courtesy and assistance which has always been made available to me by the officers and staff of the HCMA and I take this opportunity to extend best wishes for success to all of you.

Donn L. Smith, M.D.
Tampa

Reprinted from The Bulletin of the Hillsborough County Medical Association, October 1976.

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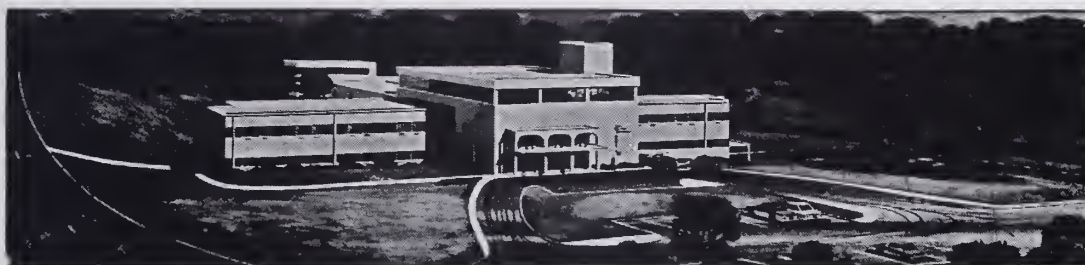
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MEETINGS

Approved by FMA Committee on Continuing Medical Education

1977

JANUARY

Second National Symposium on Stress, Jan. 13-15, Hilton Hotel, Gainesville**

Oncology-Hematology 1977, Jan. 13-16, Fontainebleau Hotel, Miami Beach*

Nephrology 1977, Jan. 14-15, Fontainebleau Hotel, Miami Beach*

Pulmonary Disease 1977, Jan. 14-15, Miami*

Tomorrow's Diagnoses and Next Year's Treatment, Jan. 14-15, Fontainebleau Hotel, Miami Beach*

Cardiology 1977, Jan. 14-16, Fontainebleau Hotel, Miami Beach*

Arthritis 1977, Jan. 14-16, Miami*

Gastroenterology and Hepatology 1977, Jan. 14-16, Fontainebleau Hotel, Miami Beach*

Coronary Disease, Exercise Testing & Cardiac Rehabilitation, Jan. 14-16, Orlando Hyatt House, Orlando. For information: William E. James, Ph.D., One Inverness Drive, Englewood, Colo. 80110.

Internal Medicine 1977, Jan. 15-21, Fontainebleau Hotel, Miami Beach*

Second Review and Practical Advances in Pathology, Jan. 16-21, Miami*

Fourth Annual Postgraduate Seminar in Pediatric Neurology, Jan. 17-21, Konover Hotel, Miami Beach*

Southeastern Breast Oncology Conference, Jan. 17-21, Marriott Hotel, Miami. For information: Oswald H. Coury, M.D., 7211 Southwest 62nd Ave., South Miami 33143.

Internal Medicine Update '77, Jan. 17-22, Dutch Inn, Lake Buena Vista. For information: Barry E. Sieger, M.D., 1416 S. Orange Avenue, Orlando 32806.

Recent Advances in Cardiovascular Surgery, Jan. 18, Martin Memorial Hospital, Stuart. For information: Carlos Maldonado, M.D., 931 East Ocean Blvd., Stuart 33494.

Mease Hospital Tumor Board, Jan. 20, Mease Hospital, Dunedin. For information: Paul S. Berger, M.D., 725 Virginia Street, Dunedin 33528.

9th Annual Postgraduate Seminar in Pediatric & Adult Urology, Jan. 19-22, Carillon Hotel, Miami Beach. For information: Charles Lynne, M.D., 1200 N.W. 10th Avenue, Miami 33136

19th Annual Cardiovascular Seminar, Jan. 21-22, Tampa.+

Continuing Education in Abdominal Diagnostic Ultrasound, Jan. 22, Mount Sinai Medical Center, Miami Beach: For information: Noel Zusmer, M.D., 4300 Alton Rd., Miami Beach 33140

Immunology-Infectious Diseases of 1977, Jan. 22-23, Fontainebleau Hotel, Miami Beach*

Pulmonary Diseases 1977, Jan. 22-23, Fontainebleau Hotel, Miami Beach*

Rheumatology 1977, Jan. 22-23, Fontainebleau Hotel, Miami Beach*

Infectious Disease—Immunology 1977, Jan. 22-23, Miami*

Endocrinology 1977, Jan. 22-23, Fontainebleau Hotel, Miami Beach*

Basic Sciences for the Practicing Physician: Biochemistry, Jan. 22-23, Miami*

Cardiology 1977, Jan. 24-26, Miami*

4th Annual Postgraduate Course in Practical Modern Neurology, Jan. 24-27, Miami*

Hematopathology, Jan. 26-28, Tampa.+

Workshop in Echocardiography, Jan. 26-29, Sheraton Sand Key, Clearwater Beach. For information: Billie N. Chiles, Coordinator, Tampa Tracings, Box 1245, Tarpon Springs 33589.

Emergency Cardiac Care—1977, Jan. 27-30, Americana Hotel, Miami Beach. For information: J. Clifford Findeiss, M.D., 3900 N.W. 79th Ave., Suite 469, Miami 33166.

Florida Midwinter Seminar on Ophthalmology, Jan. 30-Feb. 2, Miami*

First International Glaucoma Congress, Jan. 31-Feb. 1, Diplomat Hotel, Hollywood. For information: John Bellows, M.D., 6 North Michigan Avenue, Chicago, Illinois 60602.

FEBRUARY

Medical Knowledge Self-Assessment Course, Feb. 2, 9, 16, Borland Medical Library, Jacksonville. For information: JHEP, 655 W. 8th St., Jacksonville 32209.

Update on Cancers of the Gastrointestinal System, Feb. 3-5, Sonesta Beach Hotel and Tennis Club, Key Biscayne.*

Florida Midwinter Seminar on Otolaryngology, Feb. 3-5, Miami*

Eleventh Annual Symposium on Cosmetic Surgery, Feb. 3-5, Cedars of Lebanon Hospital, Miami. For information: Ms. Thelma McGregor, 1400 N.W. 12th Ave., Miami 33136

What's New in Neurosurgery for the General Practitioner, Feb. 4-5, Gainesville Hilton, Gainesville.**

Fred J. Wood Lecture Series III, Pediatrics and Adult G.U. Cancers, Feb. 4-5, Tampa.+

22nd Central Florida Medical Meeting, Feb. 4-6, Contemporary Resort, Lake Buena Vista. For information: Axel W. Anderson III, M.D., Suite 403, 85 West Miller Avenue, Orlando 32806.

*For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152, Tel. (305) 547-6716.

**For Information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143.

+For Information: Contact Theron A. Ebel, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2074.

3rd Annual Vail Conference in Anesthesiology, Feb. 5-12, Miami*

Thrombosis: Diagnosis, Prevention & Treatment, Feb. 7-9, Sonesta Beach Hotel, Key Biscayne. For information: Miniver S. Reed, 4300 Alton Road, Miami Beach 33140.

Tampa Bay Area Kidney Transplant and Procurement Program, Feb. 8, Auditorium, Manatee Memorial Hospital, Bradenton. For information: Allen R. Sklerov, M.D., 525 3rd Street E., Bradenton 33505.

Second Annual Seminar, Problems in Pediatric Radiology, Feb. 8-12, Dutch Inn, Lake Buena Vista.*

Symposium on Stroke—Moderns Trends In Cerebrovascular Disease, Feb. 9-12, Diplomat Hotel, Hollywood. For information: Mr. Ronald A. Nelson, Executor Director, Heart Association of Broward County, 440 N. Andrews Ave., Fort Lauderdale 33301

Pulmonary Embolism, Feb. 10, Conference Room, Abbey Hospital, Miami. For information: Anthony J. Pellicane, M.D., 5190 S. W. 8th St., Coral Gables 33134.

Midwinter Seminar in Ob/Gyn, Feb. 10-12, Tampa.+

Coronary Disease, Exercise Testing & Cardiac Rehabilitation, Feb. 11-13, Boca Raton Hotel & Club, Boca Raton. For information: William E. James, Ph.D., One Inverness Drive, Englewood, Colo. 80110.

South Florida Psychiatric Society Annual Symposium, Feb. 12, Dupont Plaza Center, South Miami*

Winter Management (Anesthesiology), Feb. 12-19, Miami*

Mease Hospital Tumor Board, Feb. 17, Mease Hospital, Dunedin. For information: Paul S. Berger, M.D., 725 Virginia Street, Dunedin 33528.

Psychopharmacology for the Internist, Family Practitioner and Private Psychiatrist, Feb. 18-19, Dutch Inn, Lake Buena Vista. For information: Barry E. Sieger, M.D., 1416 South Orange Avenue, Orlando 32806.

Ear Surgery: Microsurgery in 3-D, Feb. 20-24, Host Airport Hotel, Tampa+

Pediatric Dermatology Seminar, Feb. 24, Konover Hotel, Miami Beach. For information: Guinter Kahn, M.D., 16800 N.W. 2nd Avenue, N. Miami Beach 33169.

Recent Advances in Cardiopulmonary Care III, Feb. 25-26, Holiday Inn, Lido Beach, Sarasota. For information: Robert E. Windom, M.D., 1901 Arlington Street, Sarasota 33579.

Clinical Gastroenterology '77, Feb. 25-26, Dutch Inn, Lake Buena Vista. For information: Barry E. Sieger, M.D., 1416 South Orange Avenue, Orlando 32806.

Diagnostic Therapeutics, Feb. 26-27, Bahia Mar Hotel, Ft. Lauderdale. For information: M. J. DeAlmeida, M.D., 4330 West Broward Blvd., Ft. Lauderdale 33317.

Basic Neurology for Psychiatrists, Feb. 28-Mar. 4, Miami*

5th Annual Workshop on Methods of Analysis and Principles of Instrumentation in the Clinical Laboratory, Feb. 28-Mar. 4, Tampa+

MARCH

Medical Knowledge Self-Assessment Course, Mar. 2, 9, 16, 30, Borland Medical Library, Jacksonville. For information: JHEP, 655 W. 8th St., Jacksonville 32209.

Infectious Diseases 1977—Treatment and Prevention, Mar. 3-4, Cedars of Lebanon Health Care Center, Miami. For information: Ms. Thelma MacGregor, Seminar Coordinator, Box 520793, Miami 33136.

Third Annual Pediatric Surgical Postgraduate Course, Mar. 3-5, Americana Hotel, Miami Beach. For information: William T. Brown, M.D., Chief, Department of Surgery, Variety Children's Hospital, 6125 S.W. 31st St., Miami 33155.

Selected Topics in Urology, Mar. 3-5, Hilton Hotel, Gainesville**

Postgraduate Seminar in Dermatology, Mar. 4-6, Miami*

Skin 1977: What Every Nurse Should Know, Mar. 4-6, Miami*

Pediatric Anesthesia Seminar—Spring Cruise, Mar. 5-15, Miami*

3rd Annual USF Cancer "Tumors of the Genitourinary Tract," March 5, Tampa.+

Mediclinics, Mar. 7-18, Galt Ocean Mile Hotel, Fort Lauderdale. For information: Walter J. Glenn, M.D., 1106 E. Broward Blvd., Fort Lauderdale 33301.

Annual Suncoast Trauma Seminar, March 9-11, University of South Florida, Tampa+

A Symposium in Gynecologic Endocrinology and Infertility, March 10-12, Hyatt House, Orlando. For information: B. Cantor, M.D., P.O. Box 13284, University Sta., Gainesville 32604

Basic Medical Hypnosis, Mar. 13-19, Miami*

Gynecologic Oncology Seminar, Mar. 15-26, Cruise*

Tenth Anniversary JHEP Instructional Course on Surgery of the Hand, March 16-20, Amelia Island. For information: Ira M. Dushoff, M.D., 580 W. 8th St., Jacksonville 32209.

Neurology for Non-Neurologist V: Movement Disorders, March 17, Tampa.+

Mease Hospital Tumor Board, March 17, Mease Hospital, Dunedin. For information: Paul S. Berger, M.D., 725 Virginia Street, Dunedin 33528.

Seventh Annual Special Radiological Procedures Seminar, Mar. 19-22, Konover Hotel, Miami Beach.*

Fifteenth Annual Clinical Radiology Seminar, Advances In Cancer Diagnosis, Mar. 22-26, Konover Hotel, Miami Beach.*

9th Teaching Conference in Clinical Cardiology, Mar. 23-26, Sheraton-Four Ambassadors Hotel, Miami.*

8th Annual Topics in Internal Medicine, Mar. 24-26, Hilton Hotel, Gainesville**

Cardiology, March 25-27, Contemporary Hotel, Lake Buena Vista. For information: Jonathan O. Partain, M.D., 1131 South Orange Avenue, Orlando 32806.

Post-Conventional Seminar, Pathologic-Radiologic Correlations, Mar. 26-29, Caribbean Cruise.*

2nd Annual Vail Conference in Respiratory Therapy, Mar. 26-Apr. 2, Miami*

Pulmonary Infection, Pulmonary Infarction (Embolus), Mar. 26-27, Tampa.+

Hepatitis: Diagnosis and Management, Mar. 31, Tampa.+

APRIL

Infectious Disease and Chemotherapy for the Practicing Physician, Apr. 1-2, Hyatt House, Kissimmee. For information: Barry E. Sieger, M.D., 1416 S. Orange Ave., Orlando 32806.

Medical Knowledge Self-Assessment Course, Apr. 6, 13, 20, 30, Borland Medical Library, Jacksonville. For information: JHEP, 655 W. 8th St., Jacksonville 32209.

Cardiology Update—1977, Apr. 8-9, Sheraton Inn, Jacksonville Beach. For information: JHEP, 655 W. 8th St., Jacksonville 32209.

Ninth Congress of the International Federation of Fertility Societies, Apr. 13-16, Fontainebleau Hotel, Miami. For information: Robert W. Kistner, M.D., c/o Ms. Pat Shannon, Exec. Sec., American Fertility Society, 1608 13th Avenue, S., Birmingham, Alabama 35205.

Practical Electrocardiography and Arrhythmia Management for the Family Practitioner, Apr. 14-16, Hilton Hotel, Gainesville**

Postgraduate Seminar on Arthritis & Related Diseases, April 21-23, Hilton Hotel, Jacksonville. For information: Louis M. Sales, M.D., 2522 Oak Street, Jacksonville 32205.

Mease Hospital Tumor Board, April 21, Mease Hospital, Dunedin. For information: Paul S. Berger, M.D., 725 Virginia Street, Dunedin 33528.

Common Problems in Ocular-Plastic Surgery, Apr. 30, Tampa+

MAY

Florida Medical Association 103rd Annual Meeting, May 4-8, Americana Hotel, Miami Beach.

Master Approach to Cardiovascular Problems, May 5-7, The Contemporary Hotel, Walt Disney World**

Asymptomatic Coronary Artery Disease: Early Detection and Management, May 12-14, Innisbrook Resort, Tarpon Springs**

Mease Hospital Tumor Board, May 19, Mease Hospital, Dunedin. For information: Paul S. Berger, M.D., 725 Virginia Street, Dunedin 33528.

Fifth Family Practice Review, May 23-27, Hilton Hotel, Gainesville**

JUNE

Florida Suncoast Pediatric Conference, Second Annual Meeting, June 12-15, Sheraton Sand-Key, Clearwater Beach+

Mease Hospital Tumor Board, June 16, Mease Hospital, Dunedin. For information: Paul S. Berger, M.D., 725 Virginia Street, Dunedin 33528.

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Classified Ads

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INTERNIST, board eligible, university-trained. Seeks group or partnership in general internal medicine. Send for curriculum vitae. Write C-768, P.O. Box 2411, Jacksonville, Florida 32203.

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INTERNIST—SUBSPECIALTY ALLERGY, board certified in both, Florida license, American graduate, ten years practice experience, desires group or solo practice. Write C-767, P.O. Box 2411, Jacksonville, Florida 32203.

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GP/FP, widely experienced in family type practice. Florida license, seeking partnership or interesting opportunity. Write 41 Tara Drive, Roslyn, N.Y. 11576 or phone (516) 626-3518.

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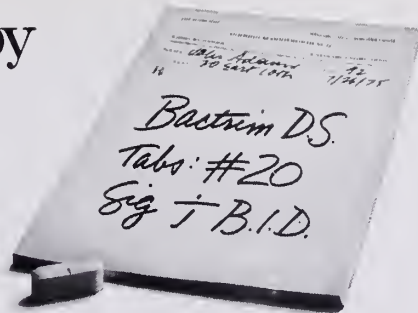
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**1977 Florida Medical Association Annual Meeting,
 May 4-8, Americana Hotel, Miami Beach**

10-day Bactrim therapy outperforms 10-day ampicillin therapy.



In a multicenter, double-blind study of patients with chronic or frequently recurrent urinary tract infection, Bactrim 10-day therapy outperformed ampicillin 10-day therapy by 27.2%, when comparing patients who maintained clear cultures for eight weeks. Criterion for "clear culture" was 1000 or fewer organisms/ml of urine.

While adverse reactions noted in this study were mild (e.g., vomiting, nausea, rash), more serious reactions can occur with these drugs. See manufacturer's product information for complete listing. Maintain adequate fluid intake; perform frequent CBC's and urinalyses with microscopic examination.

Note: Bactrim tablets were used in these clinical trials. Bioequivalency studies show one Bactrim DS double strength tablet is equivalent to two Bactrim tablets.

For chronic or frequently recurrent cystitis and pyelonephritis due to susceptible organisms.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Chronic urinary tract infections evidenced by persistent bacteriuria (symptomatic or asymptomatic), frequently recurrent infections (relapse or reinfection), or infections associated with urinary tract complications, such as obstruction. Primarily for cystitis, pyelonephritis or pyelitis due to susceptible strains of *E. coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris* and *Proteus morganii*.

NOTE: The increasing frequency of resistant organisms limits the usefulness of antibacterials, especially in these urinary tract infections. The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. **Data are insufficient to recommend use in infants and children under 12.**

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprotrombinemia and methemoglobinemia. *Allergic reactions:* Erythema

Bactrim™ DS

(160 mg trimethoprim and 800 mg sulfamethoxazole)
Double Strength tablets
Just 1 tablet B.I.D.

Bactrim™

(80 mg trimethoprim and 400 mg sulfamethoxazole)
2 tablets B.I.D.

multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for children under 12. Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) every 24 hours
Below 15	Use not recommended

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole — bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10.

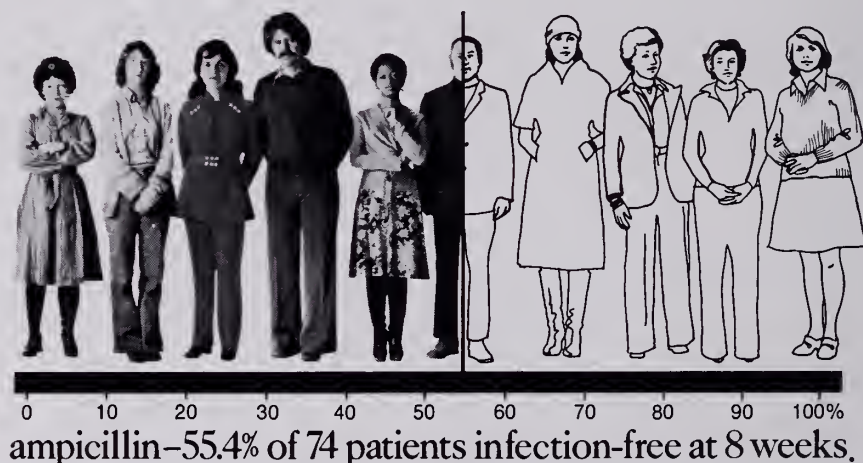
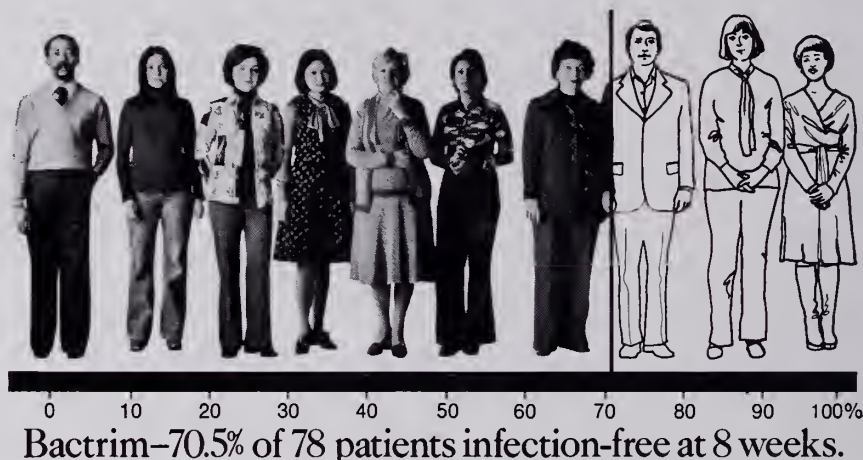
Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole; fruit-licorice flavored — bottles of 16 oz (1 pint).



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

In a multicenter study of patients with chronic or frequently recurrent urinary tract infections

Bactrim was 27.2%* more effective than ampicillin in keeping patients infection-free for 8 weeks.†



*This percentage is arrived at by the statistical method of dividing the difference between Bactrim and ampicillin results (15.1%) by the percent of ampicillin results (55.4%).

†Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey 07110

BactrimTM DS
(160 mg trimethoprim and 800 mg sulfamethoxazole)

Double Strength tablets
Just 1 tablet B.I.D.

THE FLORIDA MEDICAL ASSOCIATION



FEBRUARY 1977 • VOL 64 • NO 2

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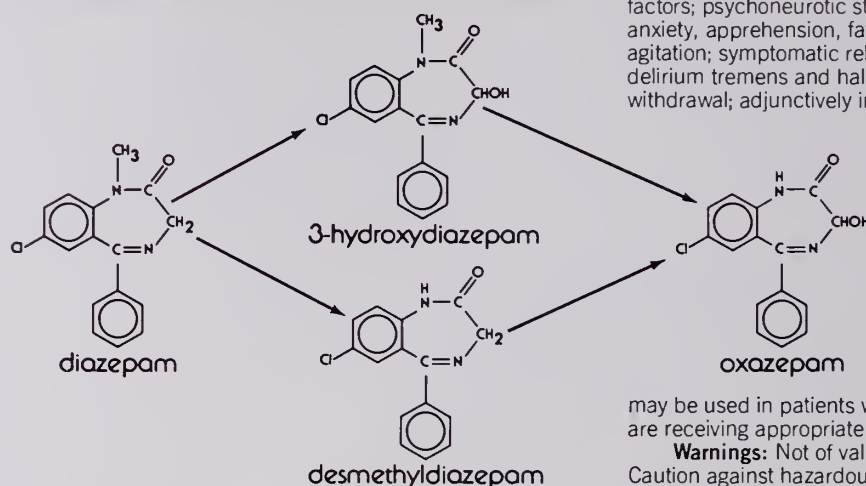


MDS



This issue of The Journal was designed to pay tribute to the Auxiliary of the FMA. See their publication, "The Beeper," page 74a.
See Summary of the FMA Board of Governor's Meeting, January 15, 1977, page 78a.

A pharmacokinetic character all its own



Valium (diazepam) is a benzodiazepine with a distinctive pharmacokinetic profile

The pharmacokinetic profile of Valium is one of the characteristics that sets it apart from other benzodiazepines. Consider, in particular, the metabolic pathway of Valium. The three major metabolites of Valium exhibit significant pharmacologic activity—and so, of course, does the parent substance—diazepam itself. All combine to produce the characteristic clinical response seen with Valium. The response you have come to know, to want and to trust.

Pharmacokinetic studies also demonstrate that Valium has a pattern of absorption, distribution, metabolism and elimination that is reliable and consistent. And, although the pharmacokinetics of a drug cannot, at present, be specifically related to its clinical effects, it is clearly a factor that distinguishes one product from another by providing important insights into how each moves through the patient's body.

Valium® (diazepam) ^{IV}

2-mg, 5-mg, 10-mg scored tablets
**a prudent choice in psychic
tension and anxiety**

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated:

Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma;

may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients.

Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

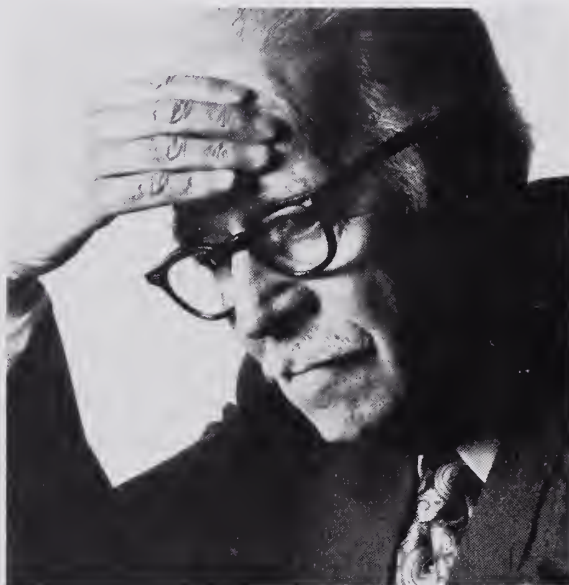
A TOTALLY NEW DELIVERY SYSTEM TO HELP REDUCE THE FEAR OF ANGINAL ATTACKS

Round-the-clock
protection with

ISO-BID

(ISOSORBIDE DINITRATE)

40 mg. capsules ... twice-a-day dosage



Controlled sustained release of ISO-BID's isosorbide dinitrate through micro-dialysis diffusion can help reduce frequency and intensity of anginal attacks. This in turn can minimize patient's fear of attacks, and dependence on nitroglycerin.

Unlike ordinary sustained release products, ISO-BID releases isosorbide dinitrate at a smooth, continuous, predictable, controlled rate to provide for up to 12 hours of therapeutic activity. Micro-dialysis is dependent only upon the presence of fluid in the G.I. tract and not on pH or other variables. ISO-BID is particularly advantageous in the prevention of nocturnal angina.

DOSAGE: One ISO-BID capsule every 12 hours on an empty stomach according to need, for continuous 24-hour therapy. Some patients may require higher dosage levels. In these patients, dosage should be titrated, and they may require two ISO-BID capsules b.i.d. Not intended for sublingual use. Consult product brochure before prescribing.

THERAPEUTIC FOOTNOTE: IN TREATING ANGINA . . . FAILURES MAY RESULT FROM INADEQUATE DOSAGE. Reports in the literature indicate the usefulness of higher dosage levels of isosorbide dinitrate.^{1,2}

INDICATIONS: Based on a review of this drug by the National Academy of Sciences — National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: For the relief of angina pectoris (pain of coronary artery disease). ISO-BID is not intended to abort the acute anginal episode, but is widely regarded as useful in the prophylactic treatment of angina pectoris. Final classification of the less-than-effective indication requires further investigation.

CONTRAINDICATION: Idiosyncrasy to this drug.

WARNINGS: Data supporting the use of nitrites during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety.

PRECAUTIONS: Use with caution in patients with glaucoma. Tolerance to this drug, and cross-tolerance to other nitrates and nitrites may occur.

ADVERSE REACTIONS: Cutaneous vasodilation with flushing. Headache may commonly occur, and may be both severe and persistent. Transient dizziness

and weakness, in addition to other signs of cerebral ischemia associated with postural hypotension may occasionally be seen. ISO-BID can act as a physiological antagonist to norepinephrine, histamine, acetylcholine and many other medications. An occasional patient may show marked sensitivity to the hypotensive effects of nitrite; severe responses (nausea, vomiting, weakness, restlessness, pallor, excessive sweating and collapse) can occur, even with the usual therapeutic dosage; alcohol may enhance this effect. A drug rash and/or exfoliative dermatitis is occasionally seen.

SAMPLES AND LITERATURE AVAILABLE.

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1. Shane, S.J.: Canadian Family Physician, November 1973. 2. Lemberg, L.: Practical Cardiology, February 1976.





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FEBRUARY COVER—The cover of the February issue represents the salient theme of this month's Journal—the symbiotic relationship of the Florida Medical Association and its Auxiliary.

The seals of these organizations portray the oft-repeated credo, "We Can Do More Together."



President's Page

"National Health Insurance is Just Around the Corner"

I have heard this periodically since I entered practice over twenty years ago, and apparently it is time to face the issue again. Each time the problem surfaces it seems to inch a little closer to reality. Therefore, it behooves us to give it serious attention, since it may succeed in coming into being. Certainly the taxpayers are paying for more and more of the medical costs each year.

Who wants compulsory National Health Insurance? Almost everybody. The Democratic platform has it as one of its main planks. President Carter has repeatedly affirmed his personal commitment on its behalf. George Meany has demanded a National Health program as Labor's spokesman. HEW spokesmen since Wilbur Cohen have proclaimed its virtues. Although a Roper poll in 1974 had medical costs rated sixteenth on the public's worry list, we are now told the public favors a National Health scheme. And now, finally, the front-page headlines in the December 13, 1976, AMERICAN MEDICAL NEWS read, "Delegates reaffirm support for N.H.I. bill." Therefore, if the President, the Government, Labor, the general public, and now the doctors themselves want it, who then is against it?

At the AMA meeting in Philadelphia, our Past President Joseph Von Thron, debating the issue on the floor of the house, eloquently pointed out, "I know of no other national industry that has a bill to nationalize itself, except medicine. The AMA is the last positive political force for medicine. If we sacrifice our independence for an intellectually dishonest bill, what then can we expect from Congress?" Our AMA delegates, in keeping with the wishes of the FMA House of Delegates, voted unanimously against supporting HR 6222.

What then can we expect in 1977. The sluggish economy has prevented any serious consideration of a bill these past two years, and is still not healthy enough to withstand such an insult. It is estimated that \$140 billion dollars was spent on health needs in this country last year. Conservative estimates of the cost, if the Government footed the bill and all services were "free", run it well over the \$200 billion dollar mark. Even our new Congress would have to think that price tag over. Carter men announced January 6, 1977, that no bill is expected this year. Hearings will get under way, and plans formulated for a phasing-in type of program to soften the impact on the budget.

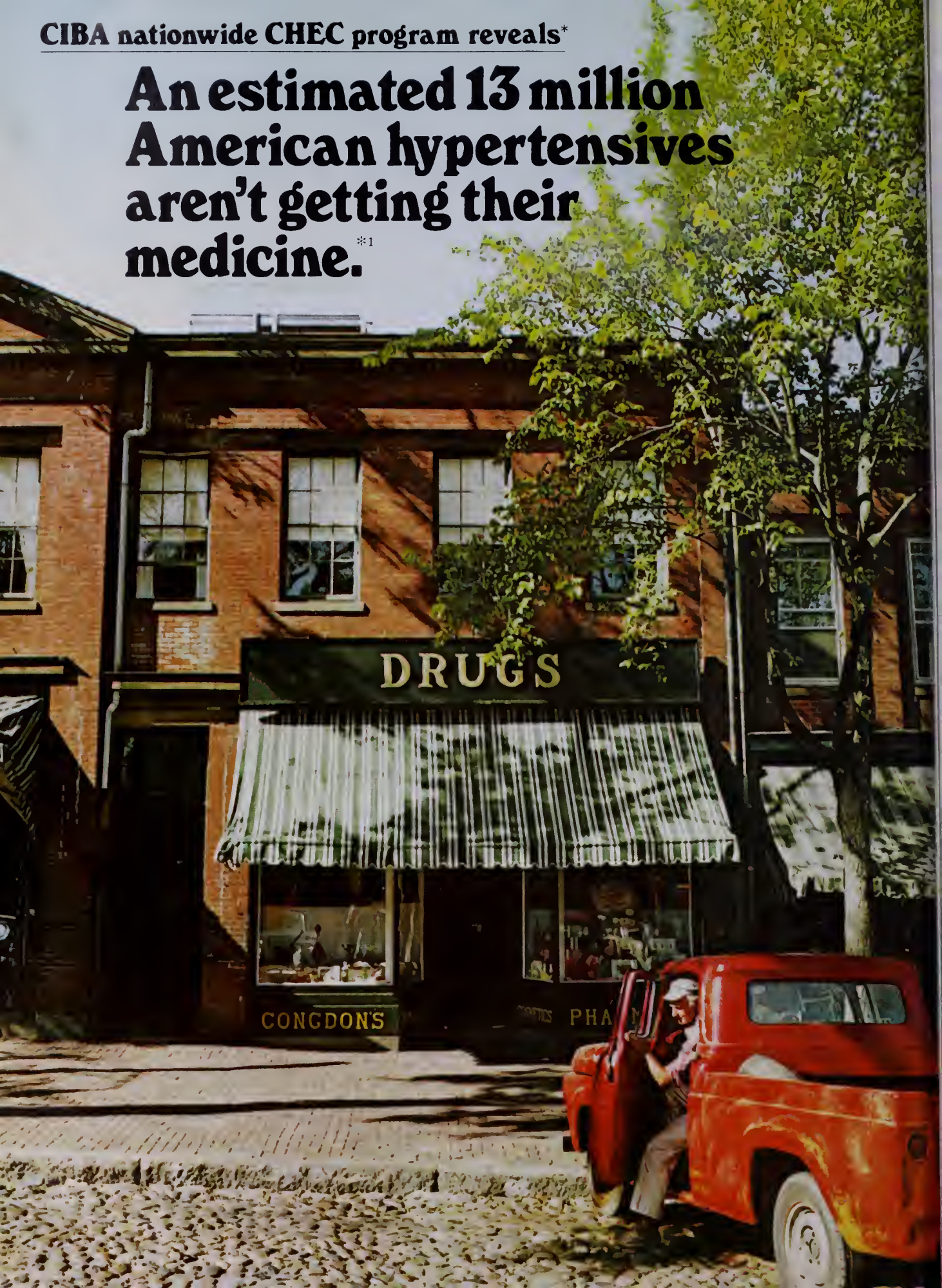
By supporting a National Health Insurance bill, are we not setting the stage for our own take-over? Could not the present administration simply take the AMA bill, send it through the two houses of Congress to modify it a bit, and pass it out as the "Doctors' Bill?" Then each year it could be molded by regulations published in the Federal Register, as is being done with the Medicare Law?

Thus, once again we are given time to act. We have two projects of prime importance. (1) Inform the taxpayer regarding NHI; its costs, its associated bureaucracy and red tape, and ultimately the deterioration and delay of medical treatment. (2) Set forth a program to take the place of Medicaid to aid the needy sick, and allow the large majority who can provide for themselves to do so.

Jack A. Walulis

CIBA nationwide CHEC program reveals*

**An estimated 13 million
American hypertensives
aren't getting their
medicine.*1**



Here's one patient who has stayed with his regimen for 8 years.

For hypertensive patient Barney Platt,** hypertension has been controlled for nearly a decade with Ser-Ap-Es.

For millions of other hypertensives, the long-term answer to the problem of blood pressure control can be Ser-Ap-Es also.

Hydralazine makes the difference...

because Ser-Ap-Es contains Apresoline® (hydralazine), the peripheral vasodilator that acts directly at the site of hypertension by increasing the diameter of constricted arterioles. And, in the presence of slight renal impairment, hydralazine helps maintain or even increase renal blood flow, which can help consistently maintain control of this disease over the years.

Ser-Ap-Es also contains an effective potentiator of hydralazine — hydrochlorothiazide

— which reduces body sodium and fluid volume. Reserpine completes the package by reducing sympathetic vascular tone.

Once dosage of individual components is titrated to your patient's needs, Ser-Ap-Es can be a logical choice for long-term therapy.

Use Ser-Ap-Es cautiously in patients with advanced renal damage or cerebrovascular accident. Discontinue at first sign of mental depression.

* CHEC (Community Hypertension Evaluation Clinic), the program that screened 1,049,225 Americans for hypertension, showed that 55.1% of the hypertensives screened were previously undetected, untreated, or uncontrolled. The 13 million figure is a projection based on this percentage and the estimated 24 million hypertensives in the United States. CHEC was a two-year, nationwide study sponsored by CIBA and local health organizations.¹

** Barney Platt is a pseudonym for an actual case history.

Please turn page for prescribing information.

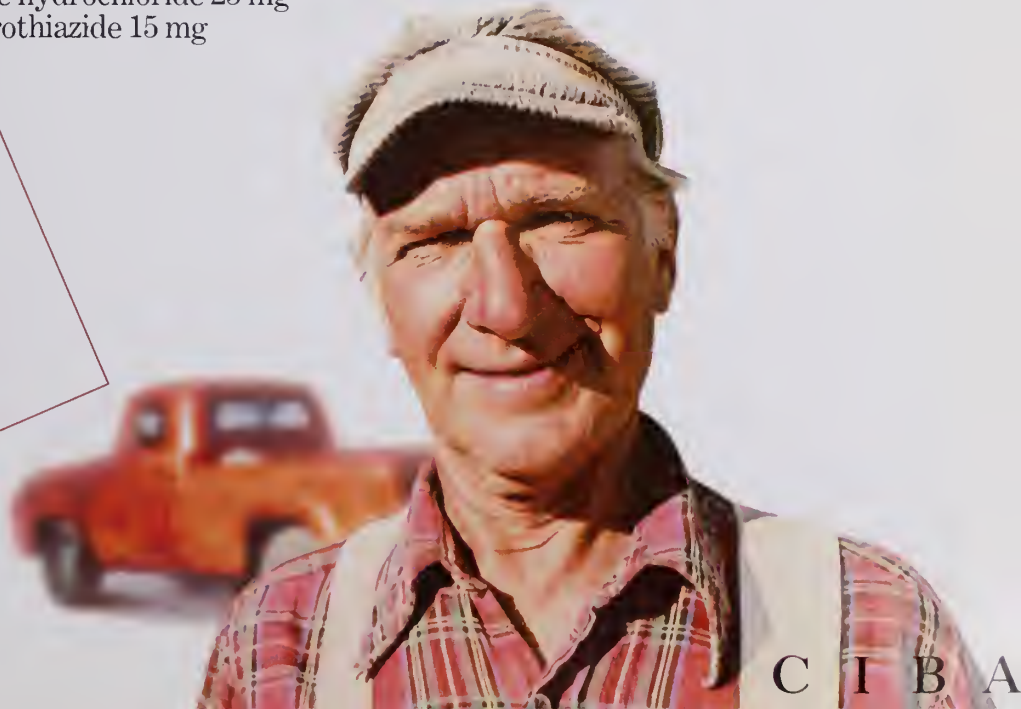


Therapy planned for life

Ser-Ap-Es®

reserpine 0.1 mg
hydralazine hydrochloride 25 mg
hydrochlorothiazide 15 mg

So they'll get
the medication you
prescribe...write
*medically
necessary*
on every Rx.



Ser-Ap-Es®

reserpine 0.1 mg
hydralazine hydrochloride 25 mg
hydrochlorothiazide 15 mg

Therapy planned for life

Ser-Ap-Es®

reserpine 0.1 mg
hydralazine hydrochloride 25 mg
hydrochlorothiazide 15 mg

WARNING

This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

INDICATIONS

Hypertension. (See box warning.)

CONTRAINDICATIONS

Reserpine: Known hypersensitivity; mental depression (especially with suicidal tendencies); active peptic ulcer; ulcerative colitis; electroconvulsive therapy.

Hydralazine: Hypersensitivity; coronary artery disease; mitral valvular rheumatic heart disease.
Hydrochlorothiazide: Anuria; hypersensitivity to this or other sulfonamide-derived drugs.

WARNINGS

Reserpine: Use with extreme caution in patients with a history of mental depression. Discontinue at first sign of despondency, early morning insomnia, loss of appetite, impotence, or self-deprecation. Drug-induced depression may persist for several months after drug withdrawal and may be severe enough to result in suicide.

MAO inhibitors should be avoided or used with extreme caution.

Hydralazine: Hydralazine may produce in a few patients a clinical picture simulating systemic lupus erythematosus. In such patients hydralazine should be discontinued unless the benefit to risk determination requires continued antihypertensive therapy with this drug. Symptoms and signs usually regress when the drug is discontinued but residua have been detected many years later. Long-term treatment with steroids may be necessary.

CBC's, L.E. cell preparations, and antinuclear antibody titer determinations are indicated before and periodically during prolonged therapy with hydralazine or if the patient develops any unexplained signs or symptoms.

A positive antinuclear antibody titer and/or positive L.E. cell reaction requires that the physician carefully weigh the implications of the test results against the benefits to be derived from antihypertensive therapy with hydralazine.

Use MAO inhibitors with caution.

Hydrochlorothiazide: Use with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects of the drug may develop in patients with impaired renal function.

Thiazides should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte imbalance may precipitate hepatic coma. Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs.

Sensitivity reactions are more likely to occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

Usage in Pregnancy

Reserpine: The safety of reserpine for use during pregnancy or lactation has not been established; therefore, the drug should be used in pregnant patients or women of childbearing potential only when, in the judgment of the physician, it is essential to the welfare of the patient. Increased respiratory tract secretions, nasal congestion, cyanosis, and anorexia may occur in neonates and breast-fed infants of reserpine-treated

mothers since reserpine crosses the placental barrier and appears in maternal breast milk.

Hydralazine: Animal studies indicate that high doses of hydralazine are teratogenic in mice, possibly in rabbits, and not in rats. Although clinical experience does not include any positive evidence of adverse effects on the human fetus, hydralazine should be used during pregnancy only if the benefit clearly justifies the potential risk to the fetus.

Hydrochlorothiazide: Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnant women requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

Nursing Mothers: Thiazides appear in breast milk. If the use of the drug is deemed essential, the patient should stop nursing.

PRECAUTIONS

Reserpine: Use cautiously in patients with history of peptic ulcer, ulcerative colitis, or gallstones (biliary colic may be precipitated).

Exercise caution when treating hypertensives with renal insufficiency. Use cautiously with digitalis and quinidine.

Intraoperative hypotension has occurred in hypertensive patients receiving rauwolfia preparations, but withdrawal of reserpine does not assure that circulatory instability will not occur in such patients.

Hydralazine: Use cautiously in suspected coronary artery or other cardiovascular disease, cerebral vascular accidents, and advanced renal damage. Postural hypotension may occur, and the pressor response to epinephrine may be reduced. Peripheral neuritis, evidenced by paresthesias, numbness, and tingling, has been observed. Published evidence suggests an antipyridoxine effect and addition of pyridoxine to the regimen if symptoms develop.

Blood dyscrasias, consisting of reduction in hemoglobin and red cell count, leukopenia, agranulocytosis, and purpura, have been reported. If such abnormalities develop, discontinue therapy. Periodic blood counts are advised during prolonged therapy.

Hydrochlorothiazide: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals. Observe patients for clinical signs of fluid or electrolyte imbalance (hyponatremia, hypochloremic alkalosis, and hypokalemia).

Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbance such as nausea or vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of steroids or ACTH.

Interference with adequate oral intake of electrolytes will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effects of digitalis (eg, increased ventricular irritability).

Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver diseases or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Latent diabetes may become manifest during thiazide administration. Thiazide drugs may increase the responsiveness

to tubocurarine. The antihypertensive effects of the drug may be enhanced in the post-sympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathological changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism such as renal lithiasis, bone resorption, and peptic ulceration have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

ADVERSE REACTIONS

Reserpine: *Gastrointestinal*—hypersecretion; nausea; vomiting; anorexia; diarrhea. *Cardiovascular*—angina-like symptoms; arrhythmias (particularly when used concurrently with digitalis or quinidine); bradycardia. *Central Nervous System*—drowsiness; depression; nervousness; paradoxical anxiety; nightmares; rare parkinsonian syndrome and other extrapyramidal tract symptoms; CNS sensitization (manifested by dull sensorium, deafness, glaucoma, uveitis, and optic atrophy). *Miscellaneous*—frequently nasal congestion; pruritus; rash; dryness of mouth; dizziness; headache; dyspnea; syncope; epistaxis; purpura and other hematological reactions; impotence or decreased libido; dysuria; muscular aches; conjunctival injection; weight gain; breast engorgement; pseudolactation; gynecomastia; rarely water retention with edema in hypertensive patients.

Hydralazine: *Common*—headache; palpitations; anorexia; nausea; vomiting; diarrhea; tachycardia; angina pectoris. *Less frequent*—nasal congestion; flushing; lacrimation; conjunctivitis; peripheral neuritis, evidenced by paresthesias, numbness, and tingling; edema; dizziness; tremors; muscle cramps; psychotic reactions characterized by depression, disorientation, or anxiety; hypersensitivity (including rash, urticaria, pruritus, fever, chills, arthralgia, eosinophilia, and, rarely, hepatitis); constipation; difficulty in micturition; dyspnea; paralytic ileus; lymphadenopathy; splenomegaly; blood dyscrasias, consisting of reduction in hemoglobin and red cell count, leukopenia, agranulocytosis and purpura; hypotension; paradoxical pressor response.

Hydrochlorothiazide: *Gastrointestinal*—anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (irreversible cholestatic), pancreatitis, sialadenitis. *Central Nervous System*—dizziness, vertigo, paresthesias, headache, xanthopsia. *Hematologic*—leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia. *Cardiovascular*—orthostatic hypotension (may be potentiated by alcohol, barbiturates, or narcotics). *Hypersensitivity*—purpura, photosensitivity, rash, urticaria, necrotizing angitis, Stevens-Johnson syndrome, and other hypersensitivity reactions. *Other*—hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness. Whenever adverse reactions are moderate or severe, reduce dosage or withdraw therapy.

DOSEAGE

As determined by individual titration (see box warning).

Usual dosage is 1 or 2 tablets t.i.d. For maintenance, adjust dosage to lowest patient requirement. When necessary, more potent antihypertensives may be added gradually in dosages reduced by at least 50 percent.

HOW SUPPLIED

Tablets (light salmon pink, dry-coated), each containing 0.1 mg reserpine, 25 mg hydralazine hydrochloride, and 15 mg hydrochlorothiazide; bottles of 30, 60, 100, 1000 and Accu-Pak® blister units of 100.

Consult complete literature before prescribing.

CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901

Reference

1. Stamler J, Stamler R, Riedinger WF, et al: Hypertension screening of 1 million Americans. *JAMA* 235:2299-2306, 1976.

C I B A



25th Anniversary of the University of Miami

School of Medicine

E. M. Papper, M.D.

In October, 1976, the Editors of the Journal of the Florida Medical Association published a special issue dedicated to the University of Miami School of Medicine which recognized the 50th Anniversary of the University of Miami, and the 20th Class of physicians to be graduated from the School of Medicine. The year of 1977 marks the 25th Anniversary of the "First Accredited and Approved Medical School Established in the State of Florida." In the late 40's and early 50's, Senator R. B. Bunn Gautier from Dade County led the fight for the passage of a bill in the State Legislature which committed Florida to subsidize a medical school. The law went into effect in July 1951, when the legislature allocated \$325,000 in start-up funds to cover a period of July 1, 1951 to June 30, 1953. In September, 1952, four faculty members and 28 students inaugurated classes in an old Spanish style building originally built in 1926 to serve as a dormitory for the domestic staff of the Biltmore Hotel. Although the early years were tenuous and the School faced accreditation problems on at least two occasions, I am happy to say that the School of Medicine at the University of Miami has not only met its commitment to the State of Florida, but has become nationally and internationally recognized as a School of high quality.

A brief look at an institutional profile provided by the Association of American Medical Colleges for the years 1974 and 1975 provides evidence of the prominence of the State's first school of medicine. At present the faculty of the School of Medicine is responsible for the supervision of the 12th largest residency program in the nation. The faculty also are responsible for the professional care of the largest Medical Center in the Southeastern United States and the fourth largest in the nation. The regular operating expenditures of the Medical Affairs Division for 1974-75 was the ninth largest of any school of medicine in the nation. In 1975

the School had the 14th largest full-time faculty, and a volunteer clinical faculty membership of nearly 1,000. The School of Medicine ranks 19th among all of the nation's medical schools in sponsored programs. In a new category of the recent AAMC profile, the University demonstrated the excellence of its faculty by being pegged 18th in its ability to obtain N.I.H. approval of federal grants. These awards included a Comprehensive Cancer Center which was the ninth approved and funded in the United States, the third Sickle Cell Center opened in the nation, establishment of one of the earliest programs to study the development of atherosclerosis in infants and children (SCOR Project), and a recently awarded and funded Hemophilia Center.

The emergence of our School of Medicine has been paralleled by the evolution of Jackson Memorial Hospital, our School's primary teaching facility. The October issue of the Journal of the Florida Medical Association described the tremendous progress which has taken place in the University of Miami-Jackson Memorial Medical Center. Within the next several weeks, ground will be broken for the new Primary Care-Ambulatory Health Center. Immediately thereafter, construction will begin on the new Rehabilitation Center. New intensive care units for a variety of tertiary disease problems are now under construction. Within the next several months, we anticipate the destruction of East Wing, Woodard and Skaggs; old hospital facilities that years ago outlived their usefulness. During the next 90 days the Health System Agency will be reviewing the Public Health Trust's request for a Certificate of Need to build additional clinical laboratories, a new Emergency Room, as well as a desperately needed Maternal and Child Clinical Tower to replace the buildings that will be pulled down. The completion of the replacement buildings will provide clinical facilities commensurate with the outstanding professional talent that has been recruited to South Florida to complement the Medical Center's superb Veterans Administration Hospital.

Dr. Papper is Vice President for Medical Affairs and Dean, University of Miami School of Medicine, Miami.

To commemorate the 25th Anniversary of the University of Miami School of Medicine we are planning to sponsor several special scientific symposia during the fall. The first will be held in September in conjunction with an anniversary banquet honoring our alumni, faculty, students, and friends that have made the achievements of our Medical School possible.

We are especially appreciative for the many Dade County physicians who served on the School's clinical faculty particularly during the early years.

They provided an important source of talent which has resulted in a strong relationship between the Dade County Medical Association and the Florida Medical Association.

As the events of our anniversary year unfold, an attempt will be made to keep the readers of the Journal of the Florida Medical Association apprised of our progress in the Dean's Page.

► Dr. Papper, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152.

Medical Schools Find an Intruder

Some obscure but pernicious language in a new federal law is threatening severe difficulties for American schools of medicine.

Stanford and Yale universities are seeking support now to change the law's requirements. Their initiative is welcome.

During final House-Senate conference work on a medical school assistance bill in September, unprecedented language was inserted. It requires medical schools to reserve places for Americans who were rejected before, and are pursuing their medical studies abroad. The law means that schools could lose their federal grants and loans if they refused to admit some of these previously rejected Americans.

The Administration has not yet drafted regulations to implement this mandate. No proportions or standards have been set. But even the mildest requirement would be an unwarranted intrusion.

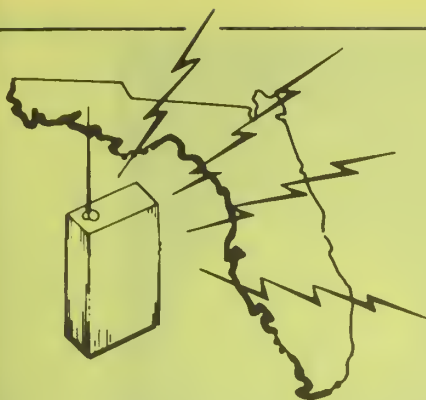
Virtually every American medical school is confronted year after year with many more qualified applicants than it has the capacity to accept and train. That some of these rejected applicants seek

training abroad is testimony of their pluck and their financial resources. It is no basis for seating the federal government on selection committees.

The issue is emotional and complex. Many schools have established controversial special admission programs to bring in more members of minority groups. Many of these minority students have college records that would otherwise shut them out of medical schools. So some rejected white applicants feel that they are victims of discrimination. That's not quite right, for the sheer numbers of outstanding applicants mean that many well-qualified whites would be turned aside whether the special programs existed or not. The expatriates are victims more of competition than of discrimination.

It is appropriate for a school to adjust its policies to help redress years of discrimination. But it is most inappropriate for government to intrude in the details of selection standards that have little to do with questions of discrimination.

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THE AUXILIARY BEEPER

FLORIDA MEDICAL ASSOCIATION AUXILIARY

FEBRUARY 1977

GOING FORWARD INTO 1977 — PROGRAMS AND PRIORITIES

FMA Priorities

The FMA priorities for 1976-77, which were outlined by FMA President Dr. Jack A. Macris to auxiliary members attending the Fall Conference in Daytona Beach, were adopted by the FMA Board of Governors at its meeting October 6-9.

These priorities are listed in the November issue of the FMA Journal. Auxiliary members should familiarize themselves with them since assistance in the attainment of FMA goals is the major "raison d'être" of the auxiliary. Some county auxiliaries are currently involved in some of these programs. Those which are not should give the appropriate ones consideration. Dr. Macris expressed appreciation for the accomplishments of the auxiliary this past year and gratitude for its support of FMA programs in the past.

AMA Priorities

AMA President, Dr. Richard E. Palmer, speaking to the AMA Clinical Convention in Philadelphia on December 5th, urged the doctors to "Go Forward — Always Go Forward." Even though the presidential election has made the future a good deal foggy for



Mrs. James White (Beebe), Dr. Jack A. Macris and Mrs. Wm. H. Harrison (Jackie).

the profession, he urged a positive and constructive spirit of courage combined with hard, ruthless logic. "In my view," he said, "ruthless logic demands interrelating what we can do in the face of everything that has to be done." He said that the profession must revise and unify its approach. It must also accept the reality that patients, as a group, are now increasingly sensitive and compose an aroused body politic. All to the effect of the Association (the AMA) on the various levels and units of government and their impact on the profession must be considered.

"Our Association is a staunch adversary of what we oppose. But we cannot be a credible and effective adversary unless we are, at the same time, a worthy advocate," he said. "We have to be positive. We've got to be on the playing field, instead of simply sitting on the grandstands, booing the other side."

The following statement from his speech on AMA activities and concerns ties in with auxiliary work beautifully: "We are actively showing the people that the government has no corner on social concern, only social pretenses. We are showing such activism through concerted health education, rural health planning, planned participation in a joint program to coordinate the care in inner cities, plus other undertakings that will affect health and life wherever people are."



Mrs. Vernon Astler (Diane) and Dr. Jack A. Macris

ANNUAL NATIONAL LEADERSHIP CONFLUENCE — 1976

The second annual AMAA Fall Leadership Confluence was held in Chicago October 10-13 at the Drake Hotel. Attending from Florida were the president and president-elect, Mrs. William H. Harrison (Jackie) and Mrs. R. B. Moore (Connie) and nine county presidents-elect: Mrs. G. L. Shiebler (Audrey) of Alachua, Mrs. J. S. Asteinza (Ginny) of Bay, Mrs. H. Pettengill (Ellen) of Brevard, Mrs. Daniel B. Nunn (Gloria) of Duval, Mrs. Charles F. McConnell (Shirley) of Escambia, Mrs. Michael J. Murray (Candy) of Lee, Mrs. T. M. McNeill (Sue) of Orange, Mrs. V. A. Marks (Susan) of Palm Beach, and Mrs. Roth D. Neller (Ann) of Pinellas.

After the opening ceremonies on Monday, conducted by Mrs. Norman H. Gardner, national president, the morning was spent in a workshop on Values Clarification conducted by Ms. Marcy Schwabenbauer and Mr. Tom Rafferty of Values Associates in Wheaton, Ill. The importance of selecting the values which are important to each person as an individual was explained.

All day Tuesday there were eight on-going seminars with an outstanding selection of subjects and faculty. Each participant selected four seminars to attend. The seminars covered the following topics: Developing Basic Writing Skills, Emergency Medical Services, How to be Politically Effective, International Health, Parliamentary Procedure, Problem Exploration in Medical Marriages, Techniques for Speakers, Violence on TV: Impact on Children.

Monday afternoon there were four Leadership Seminars held concurrently during the afternoon. These seminars were designed to provide each auxiliary leader with the opportunity to obtain information on key auxiliary programs. The subjects were: Communication, Legislation, Membership and Project Bank.

Outstanding speakers addressed the participants during most of the meals. The AMA-ERF luncheon featured Bernard Sigel, M.D., Dean of Abraham Lincoln School of Medicine, University of Illinois, College of Medicine and Richard L. Egan, M.D., Director of the Division of Educational Standards and Evaluations, AMA.

The AMPAC breakfast featured Joseph Von Thron, M.D. of Cocoa Beach, a doctor well-known and well-liked by all Floridians, and a credit to our state. Participants had the special privilege of hearing the two top officers of the AMA: President Richard E. Palmer, M.D. and Executive Vice President James H. Sammons, M.D., speak.

Dr. Palmer's remarks were on the topic, "What's This About the AMA Being Negative?" He stressed the fact that, "We of the AMA are not negatively anti-government. We are positively pro-people." He closed with the recognition of all the auxiliary has done for AMA-ERF but pointed out that we have much more work to do for the growth of medical

(continued on page 6)



Mrs. Thomas Thames (Pat)

CALENDAR OF HEALTH-RELATED EVENTS

First Vice President Mrs. Thomas B. Thames (Pat), after weeks of research, compiled a calendar of health-related events for the use of the Comprehensive Health Education teachers in their planning. 150 copies were duplicated by the auxiliary for the office of Health Education which will see that every school in the state receives one. Mr. Phil Roundtree of the state Department of Education, the teachers, the students and the auxiliary are all grateful to you, Pat, for a great job. For the record, here is the calendar for the school year 1976-77.

SEPTEMBER

Sept. 1-30	Leukemia Month
Sept. 5-6	Jerry Lewis Labor Day Telethon

OCTOBER

Oct. 3-9	Fire Prevention Week
Oct. 4	Child Health Day
Oct. 10-16	National School Lunch Week
Oct. 15	White Cane Safety Day
Oct. 17-23	Drug Abuse Prevention Week
Oct. 24-31	Cleaner Air Week
Oct. 31-Nov. 6	National Safety on the Streets Week

NOVEMBER

Nov. 1-30	National Diabetes Month
Nov. 1-30	National Retarded Citizen Month
Nov. 1-Dec. 31	Christmas Seal Campaign
Nov. 4-10	National Respiratory Therapy Week
Nov. 8-12	Meal on Wheels Week
Nov. 15-30	Epilepsy

DECEMBER

Dec. 2	Pan American Health Day
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JANUARY

Jan. 1-31	March of Dimes Birth Defects Prevention Month
Jan. 11-17	National Education Week on Smoking
Jan. 29-30	Simulated Emergency Test

FEBRUARY

Feb. 1-28	American Heart Month
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(continued on page 3)

LORIDIAN INSTALLED AS PRESIDENT OF THE WOMAN'S AUXILIARY TO THE SOUTHERN MEDICAL ASSOCIATION

Mrs. Linus W. Hewit (Jane) of Tampa was installed as the 52nd president of the Woman's Auxiliary to the Southern Medical Association on November 9 at the Royal Sonesta Hotel in New Orleans.

She is the second Florida woman to hold this office, the other being Mrs. Richard Stover (Ann) of Miami, who held it in 1952.

Mrs. Hewit was installed by Mrs. John M. Chenault (Belle) of Decatur, Alabama, a past president of A-SMA and also of the AMA-A.

The 1976 meeting had the highest registration the auxiliary has ever had — more than 500. Present from Florida were: Mrs. William H. Harrison (Jackie), MAA president; Mrs. Richard B. Moore (Connie), MAA president-elect; Mrs. Fred P. Swing (Ann), MAA treasurer; Mrs. Terry Tanner (Lynn), FMAA east central district vice president; Mrs. Robert Mitchell (Earle); Mrs. Perry D. Melvin (Judy); Mrs. Don Marion (Mable); Mrs. Ralph Jennings (Roddie); Mrs. Albert Wilson (Camille); Mrs. Larry Cohen (Betty); and Mrs. Morris Waisman (Rae).

Jane's husband is a urological surgeon. They have two daughters and one son. Jane served as FMAA president in 1968-69. She also served at the national level as AMAA Community Health Chairman, AMAA Director (two years), AMAA Secretary and AMAA Southern Regional Vice President.

In addition to her involvement with family and auxiliary, Jane has served her community in many ways over the years and is currently on the Hillsborough County Health Steering Committee, the Southeast Florida Blood Bank Board, and the Advisory Board to the Division of Children's Services. As busy as she will be with her new position of leadership in the Woman's Auxiliary to the Southern Medical Association, Jane is serving the FMAA this year as FMF (Florida Medical Foundation) Chairman. Congratulations, Jane.



Mrs. Linus W. Hewit (Jane)

CALENDAR OF HEALTH-RELATED EVENTS

(continued)

Feb. 6-12 National Children's Dental Health Week
Feb. 27 Heart Sunday

MARCH

Mar. 1-Apr. 10 Easter Seal Campaign
Mar. 1-31 Red Cross Month
Mar. 5-11 National Housing for Handicapped Week
Mar. 6-12 Save Your Vision Week
Mar. 20-26 National Poison Prevention Week
Mar. 30 Doctor's Day

APRIL

Apr. 1-30 Cancer Crusade-Cancer Control Month
Apr. 3-9 Defensive Driving Week
Apr. 18-23 Bike Safety Week
Apr. 21 Food Day
Apr. 24-30 National Volunteer Week
Apr. 23-May 7 National Baby Week

MAY

May 1-31 National Arthritis Month
May 1-31 Hearing and Speech Month
May 1-31 Mental Health Month
May 1-31 National High Blood Pressure Month
May 1-7 Cleaner Air Week
May 1 Humane Sunday
May 8-14 National Hospital Week
May 15-21 Police Week

JUNE

June 1-30 Fight the Filthy Fly Month
June 1-30 National Ragweed Control Month

JULY

July 3-9 National Safe Boating Week

AUGUST

Aug. 1-31 Good Nutrition Month



Mrs. R. B. Moore, Mrs. Robert Mitchell,
Mrs. Fred P. Swing and Mrs. Wm. H. Harrison.

OUTSTANDING COUNTY PROJECT

Appropriately enough, in this bicentennial year, a number of county auxiliaries have worked on museum projects. The Hillsborough County Medical Auxiliary is among these. They have provided a "Medical Room", complete with a remarkable assemblage of equipment, supplies, displays, furnishings and even mannequins for the Tampa Junior Museum. The medical atmosphere will be viewed *and experienced* by an expected 6000 school children during the school year.

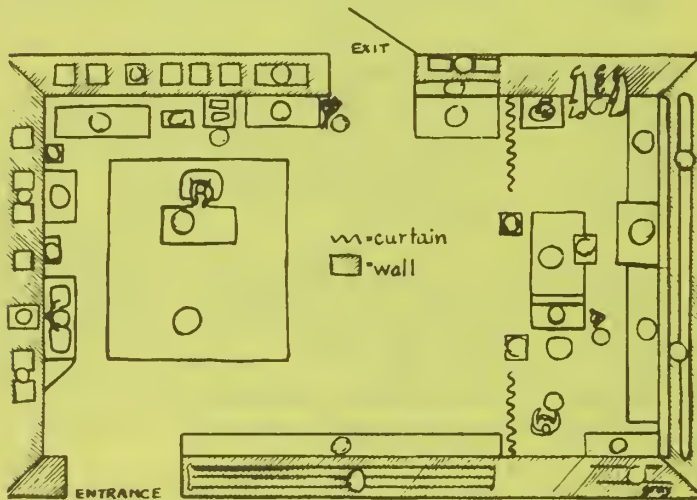
Mrs. Richard Lockley (Ann), M.D. coordinated the effort. She had the cooperation of many auxiliary members and of the medical community.

The "Medical Room" is arranged with four sections: (1) A Physician's Office where routine physical examinations are explained and children can touch and use instruments.

(2) An X-Ray Department supplied with viewing screens, a large number of x-rays, and also casts which can be applied for demonstrations.

(3) An Operating Room with a mannequin on a draped table, a scrub area, a Mayo Stand, an anesthesia cart with O.R. clothing and supplies which may be touched by the children.

(4) A display of models and specimens including a brain, heart, hip, foot, hand, eye and urinary tract. Also included are specimens of poisonous snakes, insects and plants. The American Cancer Society cooperated with an exhibit emphasizing the dangers of smoking.



The Medical Room at the Tampa Junior Museum

It is the opinion of the FMA's Committee on Sports Medicine that trampolines are unsafe even under supervised conditions. The FMA Board of Governors voted at its meeting in October to notify the Department of Education that the FMA has changed the policy adopted by the Florida School Health Advisory Committee in 1974 regarding trampolines.



THE LOLLIPOP THEATRE FOR CHILDREN

The Lollipop Theatre for Children is in its fourth season and has been well received in Dade County. And who is behind this unique enterprise? Our own South District Vice President, Mrs. David Epstein (Edie).

The Lollipop Theatre is Edie's brainchild. She writes, produces, directs, sometimes acts, provides the music and whatever else needs to be done to make the productions a total theatrical experience for children of all ages.

Edie's concept of what theatre for children should be is summed up in one word: IMAGINATION. This is how it works: A troupe of adult professional actors and actresses utilize original stories or adaptations of old ones and interpret them through music, poetry, pantomime and improvisations and then invite audience participation. Costumes are basic — either tunics or shorts, tights, shirts in primary colors with various add-on pieces to depict different characters. Sets are made up of brightly painted wooden boxes used with step ladders, trunks, and a clothes tree where indicated. Music is supplied by guitar or piano. It is a joy to see the faces of the spellbound children in the audiences. Performances last about 40 minutes and are held in theatres on Saturday afternoons, in elementary schools during the week and in centers for underprivileged children during the summer.

At the conclusion of each performance, what do you suppose is given out? LOLLIPOPS, what else!

Of all the slogans that emerged in the Bicentennial year, one seen recently at a hospital entrance probably best represents what most people wish for. It says "Healthy Birthday, America."

INTERPLAST, INC. EAST — A NEW INTERNATIONAL HEALTH PROJECT IN FLORIDA

INTERPLAST started in California with Antonio, a 14-year-old Mexican boy deformed by a congenital cleft lip and palate. Antonio came from a poor area in Mexico where surgical help was unavailable. In 1965 he was brought to Stanford University in California where Dr. Donald Laub performed basic reconstructive surgery. The surgery dramatically changed Antonio into a fine looking young man. He was able to return to his home, enter school for the first time, and shortly became a well-adjusted person in a community which had previously treated him as an outcast.

Seeing the dramatic change in Antonio's life, and realizing such cases were common in many countries, Dr. Laub and other members of the Stanford Division of Plastic and Reconstructive Surgery decided to help more children. They organized INTERPLAST, INC. to provide free surgery for children who were victims of birth defects, accidents and burns in underdeveloped countries. No child born in the U.S. must go through life in need of surgery to correct these handicaps. There are government programs in this country which provide this surgery to all children, free if needed.

Under the direction of Dr. Richard Ott of Ft. Lauderdale, a resident in Plastic and Reconstructive Surgery at Stanford University, INTERPLAST, INC. EAST has recently been established in Ft. Lauderdale.

In May of 1976, the first case was brought to south Florida — a girl named Sandra from Central America who, at 22 days of age, was severely burned by a gas lamp which fell over. After surgery Sandra was able to return to her small town, where no surgical help had been available to her, and enter school again without the fear and dread of being called "the burned girl."

Most of the surgery is performed in the children's home countries by the volunteer medical teams from the U.S. The children are brought to this country only if the surgery is so complicated or the risk of infection is so high that it is not advisable to perform it in the native country. Surgery performed overseas costs only 10% of what it costs in the U.S., often as little as \$65 per operation! This is possible because all of the professional services are donated as are most of the supplies, drugs, ancillary services and transportation. The government is not involved in any way in this program.

When a child is brought to this country, he is placed in a foster home where he lives before and after the surgery until he is completely recovered. The foster parents are volunteers. They don't get paid with anything other than love from the child and his family.

Cypress Community Hospital in Ft. Lauderdale agreed to provide free hospital care including private duty nurses around-the-clock, if needed, for six INTERPLAST patients a year. These children will be brought to Broward County on the recommendations of the INTERPLAST surgical team from Stanford University. This team makes frequent trips to the rural areas of Mexico, Honduras, Guatemala, Nicaragua,

Africa and Samoa. By the fall of '75, they had made 42 trips to these areas and performed surgery on 1240 patients.

They only go to countries where they are invited by the local doctors. While they are there, they stay in the homes of local people. In addition to surgeons, the team includes nurses, anesthesiologists, internists, pediatricians, social workers, pilots and photographers.

Ft. Lauderdale is ideally located for the headquarters of INTERPLAST, INC. EAST because of its geographical proximity to the areas being served, its fine medical facilities, the generosity of the medical community, and the large Spanish-speaking population.

As of this writing, there are four children, including two-year old twins, living in foster homes in Ft. Lauderdale and learning to know and love Americans. Concern for the health of underprivileged people of under-developed countries couldn't be more compassionately and beautifully demonstrated.



The Torres family with two-year-old twin, Jeaveny Guerrero.

WINNER OF QUILT

Mrs. Michael Berson of Riviera Beach, Florida, was the winner of the lovely quilt donated by Palm Beach County Auxiliary and raffled off for International Health.

THE BEEPER

Editor Mabel R. White (Mae)
Assistants Jo Tignor, Beverly F. Dozier
Photographer Bonnie Glotfelty
Published by the Florida Medical Association
Auxiliary. Send editorial material to Mrs. L. G.
White, 2641 N.E. 27th St., Ft. Lauderdale,
Florida 33306.

project bank



The catalogues are collecting cobwebs. Remember each deposit draws interest.

*Mrs. Roth D. Neller (Ann)
Project Bank Chairman*

ANNUAL LEADERSHIP CONFLUENCE

(continued)

education and the future of the medical profession. "Together, we need to bring our influence to bear . . . against all the misrepresentation and myths . . . that can multiply in the future. Together, we need to tell *what* we stand for . . . *why* we stand for it . . . and *whom* we stand for. We need to tell it to *those* we stand for: the American people."

Dr. Sammons stressed the importance of the auxiliary interesting itself more in the spouses of medical students, interns and residents. He believes this should be a top priority effort on the part of the auxiliary in order to acquaint these young people in the future of organized medicine.

The 1976 Confluence certainly served as the conjunction for the stream of new purposes, goals and intentions for auxiliary members to implement at the grass-root levels — the county auxiliary.

BOOKS FOR SALE

Fifteen hundred copies of "Years of Progress", the history of the first fifty years of the Woman's Auxiliary to the Florida Medical Association, are in the FMA office. These books sell for \$2.00 and would make a nice addition to your library.

Marilyn White Wells, a former state president, wrote to the author, Catherine DeVito, "I am very impressed by how the auxiliary has grown in membership, in projects and in leadership. It is hard to realize that it has been in existence for 50 years. Heavens, it's more than 45 years since I was president! You had to know I was an old lady even if my son hadn't told you. I loved what you wrote in your introduction."

Mrs. Wells' son is the fourth generation of doctors in the Wells family. He has served more than 30 years in the Navy and is now stationed in Key West where he will likely retire. He has kept up his FMA membership all these years!

Digging into history brings out all kinds of interesting facts! Buy the book and see!

PROFIT FROM TRAVEL

It is a pleasure to announce that the profit to FMF from the European Adventure tour to Switzerland, Germany and Austria, enjoyed by many FMA members, wives and friends last summer, was \$2,789.60.

The FMA has officially recognized 13 groups of Allied Health Professions. The two most recently recognized groups are: the Florida Academy of Physicians' Assistants and the Florida Society for Respiratory Therapy.

Roerig presents a guide through the labyrinth of vertigo



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Zip _____ Specialty _____



FROM THE EDITOR'S DESK

The AMA has assailed the action of the Department of HEW in making public the names of 995 physicians who received \$100,000 or more in Medicaid payments in 1975. "It simply makes a tough practice tougher for the thousands of dedicated, honest ghetto physicians," declared AMA Executive Vice President James Sammons, M.D. He called the names release "an attempt at guilt by innuendo." HEW said the information was requested by news media and others and that the Freedom of Information Act required that it be done.

* * * *

The federal government is shopping for a new Dean for its new Uniformed Services University of Health Sciences. The vacancy occurred when Anthony Curreri, M.D., resigned the post to return to the University of Wisconsin as Professor of Surgery. The salary is \$70,000 per year, the third highest paid job in the federal government.

* * * *

A government agency has called for stricter physical examinations for airplane pilots. In a report to Congress, the General Accounting Office charged that commercial pilot examinations often are less thorough than those for military pilots, air traffic controllers and foreign pilots. The GAO report suggested there are 23,000 private pilots who may represent potential safety problems, including 12,500 with records of driving cars while intoxicated.

* * * *

Roger O. Egeberg, M.D., has been appointed to a new post in the Department of HEW. Dr. Egeberg becomes special assistant for health education under Assistant Secretary for Health, Theodore Cooper, M.D. The appointment was made as part of the implementation of the new National Consumer Health Information and Promotion Act. Dr. Egeberg has been serving as Special Assistant to the Secretary for Health Policy.

* * * *

A National Academy of Sciences panel claims that a surplus of general care hospital beds is contributing to higher medical costs. The panel has proposed lowering the bed-to-population ratio from 4.4 beds per 1,000 persons to 4.0 beds by 1981. The panel estimates that 50,000 hospital beds either now in use or planned would have to be eliminated.

* * * *

The second National Conference on the Impaired Physician was held in Atlanta, February 4-6. Discussions covered successful programs and specific treatment techniques for the drug addicted, alcoholic or mentally ill physician. The conference was co-sponsored by AMA and the Medical Association of Georgia.

* * * *

The family practice residency at Polk General Hospital in Bartow was approved recently by the Liaison Committee on Graduate Medical Education. According to the American Academy of Family Physicians, there are now 303 such programs, with a total of 4,600 residents enrolled, in the United States. More than 340 programs are expected to be operational by year's end, and AAFP hopes that one fourth of all new medical school graduates will be embarking on family practice programs by 1980.

* * * *

AMA is making a \$25,000 grant to the National Citizens Committee for Broadcasting. The NCCB, a media reform group, is concerned with documenting the amount of prime time TV violence and with encouraging more thoughtful and informed choices on the part of the public, broadcasters, advertisers and producers. Last year, the AMA House of Delegates adopted the position that video violence is an environmental hazard affecting the health of children.

The Editor

consider the effect on
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(POSTERIOR VIEW OF PANCREAS)

no interference in the management of the diabetic patient has been reported with

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(ISOXSUPRINE HCl)

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TABLETS, 20 mg.

***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.
Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.
Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

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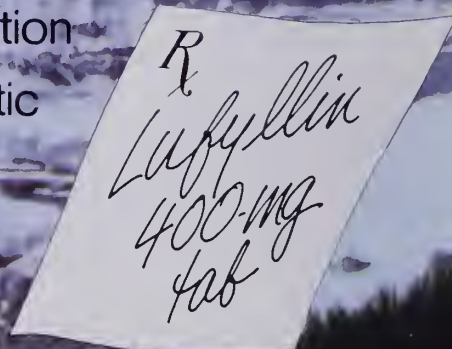
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LUFYLLIN[®]-400 (dyphylline) Tablets
Following is a Brief Summary:

Indications: For relief of acute bronchial asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema.

Contraindications: In individuals who have shown hypersensitivity to any of its components.

Dyphylline should not be administered concurrently with other xanthine preparations.

Precautions: Use with caution in patients with severe cardiac disease, hypertension, hyperthyroidism, or acute myocardial injury. Particular caution in dose administration must be exercised in patients with peptic ulcers, since the condition may be exacerbated. Chronic oral administration in high doses (500 to 1,000 mg) is usually associated with gastrointestinal irritation.

Great caution should be used in giving dyphylline to patients in congestive heart failure. Such patients have shown markedly prolonged blood level curves which have persisted for long periods following discontinuation of the drug.

Adverse Reactions: Note: Included in this listing which follows are a few adverse reactions which may not have been reported with this specific drug. However, pharmacological similarities among the xanthine drugs require that each of the reactions be considered when dyphylline is administered.

The most consistent adverse reactions are:

1. Gastrointestinal irritation: nausea, vomiting, and epigastric pain generally preceded by headache, hematemesis, diarrhea.

2. Central nervous system stimulation: irritability, restlessness, insomnia, reflex hyperexcitability, muscle twitching, clonic and tonic generalized convulsions, agitation.

3. Cardiovascular: palpitation, tachycardia, extrasystoles, flushing, marked hypotension, and circulatory failure.

4. Respiratory: tachypnea, respiratory arrest.

5. Renal: albuminuria, increased excretion of renal tubule and red blood cells.

6. Others: fever, dehydration.

Dosage and Administration: Adults—Usual Dose—15 mg/kg every 6 hours, up to four times a day. The dosage should be individualized by titration to the condition and response of the patient, with therapeutic blood levels considered to be between 10 mcg/ml and 20 mcg/ml. Levels above 20 mcg/ml may produce toxic effects.

How Supplied:

LUFYLLIN[®] Tablets—containing 200 mg dyphylline. NDC 0019-R521-92, bottles of 100; NDC 0019-R521-97, bottles of 1000.

LUFYLLIN[®] 400 Tablets—containing 400 mg dyphylline. NDC 0019-0731-92, bottles of 100.

CAUTION: Federal (U.S.A.) law prohibits dispensing without prescription.

For full prescribing information, please review package insert, or write

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Summary of the FMA Board of Governors Meeting January 15, 1977

The following is a summary of the actions taken by the Board of Governors at its meeting on January 15, 1977.

INSURANCE FRAUD

Adopted a policy statement that while the FMA condemns acts of fraud in any form and will continue to work with the State Board of Medical Examiners or any other legally constituted agency in investigations of fraud involving physicians, it is not within the purposes of the FMA to participate in the establishment of a public reward fund but that this should more properly be the responsibility of the appropriate law enforcement agency.

RISK MGT. - JUA

Directed that the FMA not participate in any manner in the lawsuit being initiated by the JUA Board to contest the constitutionality of the Risk Management/Medical Incident reporting provisions in Florida's Risk Management Law, and further that the President be requested to send a night letter to the Presidents and Executive Directors of component county medical societies clarifying the provisions of the Risk Management Law that relate to the binding nature of the findings of the medical incident Committees as to assessments against physicians.

FLA. HEALTH DATA CORP.

Approved selection of the following physicians to serve as FMA Representatives on the Board of Directors of the Florida Health Data Corporation. The purpose of this Corporation is a joint effort by the FMA, Florida Hospital Association and Florida Osteopathic Medical Association to

establish and operate an independent health data bank controlled by the private sector.

James L. Borland, Jr., M.D.
Jacksonville
Luis M. Perez, M.D., Sanford
William M. C. Wilhoit, M.D.,
Pensacola
Chauncey M. Stone, Jr., M.D.,
Miami

KEY CONTACT PHYSICIANS

Approved the U.S. Congressional Key Contact Physician Assignments for 1977.

FLAMPAC BD.

Approved the appointment of the following physicians to the FLAMPAC Board:

John C. Kruse, M.D.,
Jacksonville-District 3
Donald O. Alford, M.D.,
Tallahassee-District 2
Harold L. Williamson, M.D.
Tampa-District 7

STATE BOARD OF MEDICAL EXAMINERS

Submitted nominations of physicians to the Governor for consideration in making appointments or reappointments to the Florida State Board of Medical Examiners for terms expiring in 1977.

MISSOURI STATE MED. SOC. RES. — RE. FEDERAL LICENSURE

Expressed support for the resolution of the Missouri State Medical Society condemning legislation requiring federal licensure or relicensure of physicians and

requested FMA's AMA Delegates to support adoption of the resolution by the AMA's House of Delegates.

**SPECIALTY
GROUP
RECOGNITION**

Reaffirmed the current criteria for recognition of specialty groups, and directed that the composition of the Council on Specialty Medicine of one representative from each recognized specialty group be maintained.

**FLORIDA
THORACIC SOCIETY**

Approved the application of the Florida Thoracic Society for recognition by FMA.

**DRUG. SUBSTITUTION
LAW**

Directed that the FMA not participate in any legal action at this time regarding Florida's Drug Substitution Law.

**SECOND SURGICAL
PROGRAM**

Adopted the following policy with regard to second surgical opinion in response to the Second Surgical Opinion Program to be implemented in a seven county area in Florida by the Travelers Insurance Company and General Telephone.

"FMA believes each patient has a right to consult any physician of his choice. FMA believes each physician should give a patient his opinion concerning the patient's needs. FMA believes the principles of medical ethics already requires second opinion when the patient or the attending physician believes this to be indicated. FMA believes the intrusion of a third party into this relationship by insisting upon a second surgical opinion prior to elective surgery increases the cost of medical care and will not improve the quality of care which the citizens of Florida are now receiving."

**BLUE SHIELD
BOARD OF DIRECTORS**

Submitted nominations of physicians to the Blue Shield Nominating Committee for vacancies occurring on the Blue Shield Board in 1977.

**COMM. ON
NURSING HOMES**

Requested the Florida Hospital Association, Florida Nursing Home Association and the Florida Nurses Association to join the FMA in asking the Department of Health and Rehabilitative Services to include registered nurses on nursing home medical review teams, and exclude social workers from reviewing medical charts and records and making decisions regarding medical matters, and further that registered nurses be added to the medical

review teams, just under the physician, and that these nurses be adequately compensated.

Adopted the position that physician members of the Department of HRS, nursing home medical review teams, who make medical decisions, be licensed to practice in the State and physicians accepting a position on a nursing home medical review team should personally participate in the review and not depend on the findings of other team members.

Requested the Department of HRS to develop a clear and succinct definition of the three levels of care in nursing homes and further, that the Department develop a nursing home review policy and procedures manual to be disseminated to each member of the medical review team, each nursing home administrator and each physician assigned a Medicaid provider number.

Approved the policy that the FMA continue to encourage its members to see their nursing home patients when medically necessary, and that the FMA also request nursing home medical directors to seek assistance from county medical societies in handling physicians who are not seeing their patients when it is medically necessary.

COUNCILS AND COMMITTEES

**COUNCIL ON
LEGISLATION AND
REGULATIONS**

Approved allocation of prime staff time to try to improve Florida's Medicaid program to include adequate funding, PMUR as a quality and cost control mechanism, orientation as a medical program with high visibility in the department, and to seek different means to deliver services to indigents through medical foundations and county medical societies.

**COUNCIL ON
MEDICAL
ECONOMICS**

Reconsidered the previous action of the Board regarding modifiers in the 1975 Florida Relative Value Studies for supervision of a nurse anesthetist.

Approved the following: That Modifier -48 in the 1975 Florida Relative Value Studies be amended to state: "When the anesthesiologist is supervising the services of the nurse anesthetist **who is not in the**

employ of the supervising anesthesiologist and is involved in medical direction of the patient, including pre- and post-operative evaluation and care, but is not personally administering the anesthesia, his reimbursement shall be for the basic value of the procedures plus one unit per hour or fraction thereof, for the duration of the anesthesia. The anesthesiologist shall remain within visual and auditory range of the operating rooms under medical direction and shall extend medical direction to no more than two rooms. Medical direction excludes simultaneous administration of anesthesia by the anesthesiologist."

COMM. ON COST OF MED. CARE

Endorsed a joint pilot program of the Blue Shield Committee on Cost Containment and the FMA Committee on the Cost of Medical Care to monitor at Jacksonville Memorial Hospital, the impact of providing daily cumulative patient hospitalization charges to each attending physician on the medical staff.

Directed that the FMA request each hospital medical staff to review its hospital's routine admission orders to insure that duplication and unnecessary tests are not performed. Further recommended that each hospital medical staff develop a policy for running orders establishing limits on appropriate frequency and duration requiring the physician to reorder the services as it is medically necessary.

Supported the concept of the Duval County Foundation for Medical Care to develop an outpatient peer utilization review program.

Approved the concept of the Florida Medical Foundation through the Committee on Peer Medical Utilization Review instituting a traveling peer review team to carry out review of hospitals and physicians in hospitals not taking appropriate steps to contain costs, who are identified by the Blue Cross "Unit Cost Program".

COUNCIL ON SCIENTIFIC ACTIVITIES

Approved Research Grants from the Florida Medical Foundation totaling \$7,990.54.

RESEARCH GRANTS

"Experimental and Clinical Use of Silicone Rods for Tendon Reconstruction and Transfer in the Lower Extremities", Joseph C. Flynn, M.D., Orlando, \$1,500.00.

"An Interactive Computer Model of the Skin", Marc S. Karlan, M.D., Gainesville, \$5,034.00

"Quantitative Assessment of Lung Tissue Damage", Martin Fisher, Ph.D., Gainesville, \$1,456.54

COUNCIL ON SPECIALTY MEDICINE

Adopted the following resolution:

Whereas, it has been routine procedure at state hospitals to send discharged patients to a mental health center rather than to the physician who referred them, and

Whereas, the medical records on such patients have been sent to a mental health center without regard for the patient's right to privacy, and have not been sent to the referring physician or clinic, and

Whereas, pressure has often been exerted on patients, through interviews and printed forms prior to their discharge, to go to a mental health center instead of their own physician who referred them, and

Whereas, continuity of care and protection of privileged information are essential to good medical care and require sending a patient back to his referring physician following specialized treatment;

Therefore be it resolved, that the Florida Medical Association take all necessary action, including but not limited to, initiation of rule making proceedings, to insure:

1. That patients upon completion of treatment in a state facility are referred back to the referring physician or clinic if mutually agreeable.
2. That patients are not discouraged from returning to the physician whom they had originally chosen.
3. That the referring physician or clinic is notified of anticipated discharge or trial visit.

INTRAVENOUS INJECTIONS

4. That the appropriate reports are sent to the referring physician or clinic without delay.
5. That medical records are sent only to the referring physician or clinic unless otherwise specifically requested by the patient.

Approved the policy that a licensed physician may delegate any procedure to his employees he deems commensurate with the employee's education, training and demonstrated ability;

BLUE SHIELD

and further, that a technologist under the direction of a licensed M.D. may administer radiographic contrast agents and radio-pharmaceuticals intravenously to patients.

Approved a resolution expressing appreciation to Blue Shield for its report on its efforts to improve claim processing and that this information be widely disseminated to physicians by specialty groups.

When Big Ben looks "a little off"...

Antivert[®]/25 (meclizine HCl) 25 mg. Tablets for vertigo*

■ **Most Widely Prescribed**—Antivert is the most widely prescribed agent for the management of vertigo* associated with diseases affecting the vestibular system such as Menière's disease, labyrinthitis, and vestibular neuronitis.

■ **Relief of Nausea and Vomiting**—Antivert/25 can relieve the nausea and vomiting often associated with vertigo.*

■ **Dosage for Vertigo***—The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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RECENT CHANGES

federal register

**Providing
Drug Information
to Physicians**

**Informational
Bulletin #433-76**

**National
Health
Insurance**

special report
**Malpractice
insurance:**

**drug
bulletin**

**Health care doesn't
need more red tape**

**Drug firms challenge
'MAC' rules**

**Drug
Substitution**

RESEARCH

Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



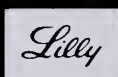
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Introduction To February Journal JFMA

This February issue of the Journal inaugurates another linkage between the Florida Medical Association and its Auxiliary.

*Their respective publications, the **Journal** itself and the Auxiliary publication "The Beeper", are for the first time combined in one publication. The key portions of the program for the annual meeting of both organizations are reproduced, with the pages of "The Beeper" retaining their distinctive color. With such early formulation of the key events and program at the annual meeting (May 4-8, 1977), it is hoped that both partners of the physician marriage couple will be attracted by the wide panorama of activities and that they will make plans to attend.*

The issue is specifically designed to include both scientific articles and special commentaries that should be of interest to both members of the physician-spouse diad. The material highlights topics of current interest and several articles relating to the challenges and opportunities inherent in a medical marriage.

The members of the Committee on Scientific Publications are most grateful to the Board of Governors and to Mrs. William H. (Jackie) Harrison and Mrs. Mae White (President of the Auxiliary and Editor of "The Beeper", respectively) for making this programmatic union possible.

G. L. Schiebler, M.D.
The Editor

Oral Contraceptives and High Blood Pressure

A Review

Melvin J. Fregly, Ph.D and Marilyn S. Fregly, Ph.D.

Abstract: Chronic use of oral contraceptive agents may be accompanied by an elevation of blood pressure in certain susceptible women. The incidence varies from 0 to 20% in the studies that have been reported to date. The large variability may be influenced by a number of cofactors, e.g., age, family history of hypertension, previous history of toxemia of pregnancy, race and preexisting renal disease. It is unknown at present how these cofactors interact. Evidence from experimental and clinical studies suggests that the estrogenic component of the oral contraceptive may be responsible. The mechanism by which blood pressure is elevated in susceptible women is unknown. Although the renin-angiotensin-aldosterone system has been implicated, present evidence does not ascribe a major role to it. Oral contraceptive agents have been reported to increase cardiac output, peripheral resistance, body water, extracellular and vascular volumes as well as to interact in renal and adrenal cortical functions. Estrogenic agents may also affect the responsiveness of the vascular system to endogenous pressor agents. It seems likely that multiple mechanisms may account for the elevation of blood pressure in susceptible users. A test to screen those who will have an elevation of blood pressure during ingestion of oral contraceptive agents remains an important research objective.

Over the past decade, oral contraceptives have been adopted by increasing numbers of women in the childbearing years. At the present time it is

estimated that over 10 million women in the United States alone are users. When one considers the large number of users both within and outside the United States, side effects of drug usage have been relatively small. In the case of some alleged "side effects," such as headache, nervousness, depression, weight gain, nausea, and vomiting, it has been impossible experimentally to separate them from placebo effects.¹ In the case of other less subjective "side effects," controversy regarding correlation with, and causation by, oral contraceptive use exists. One such side effect is elevation of blood pressure. Investigators are not in agreement regarding either the incidence of elevation of blood pressure in oral contraceptive users or the possible mechanisms by which an elevation may occur.

With respect to incidence of elevation of blood pressure, estimates ranging from 0 to 20% have been reported (Table 1). The number of women, age ranges, parity, race, and medical histories have varied considerably from study to study. The largest group of women thus far studied is 11,672. These were participants in the Kaiser Foundation Health Plan of Northern California who were followed at the Kaiser Permanente Medical Center at Walnut Creek.² The study was concerned with the prevalence of hypertensive disease among women entrants into the program during a three year period (December 1968, to December 1971). Of the total, 3,569 women had never used oral contraceptive agents and had an age-adjusted incidence of hypertensive disease of 7.8 per 1,000. Women (4,252 in all) who had used oral contraceptive agents in the past but were not ingesting them at the time of entrance into the program had a similar age-adjusted incidence (6.7 per 1,000). Those who were ingesting oral contraceptives (3,851 in all) at the time of entrance into the program had an age-adjusted incidence of hypertensive disease

From the Department of Physiology, College of Medicine, and Department of Behavioral Studies, University of Florida, Gainesville.

This study is supported by grant HL-14526-05 from the National Heart and Lung Institute.

TABLE 1 - Incidence of Oral Contraceptive-Induced Hypertension in Women (Prospective Studies).

Reference	Total Number in Study	Number Developing Hypertension	Percentage Developing Hypertension
1. Tyson, Am. J. Obstet. Gynec. 100:875, 1968.	45	7	15
2. Chernick, Canad. Med. Assoc. J. 99:593, 1968.	129	25	20
3. Saruta et al, Arch. Int. Med. 127:621, 1970.	56	10	18
4. Spellacy, Fert. Steril. 21:301, 1970.	57	9	15
5. Russell, Johns Hopkins Med. J. 127:287, 1970.	225	18	7
6. Weir et al, Lancet 1:467, 1971.	66	0	0
7. Goldzieher et al, Fert. Steril. 22:609, 1971.	267** 52(control)	23 2	8.7 3.8
8. Spellacy & Birk, Am. J. Obstet. Gynec. 112:912, 1972	123	6	5
9. Hall, Ann. Int. Med. 76:874, 1972.	42	0	0
10. Keifer, Am. J. Obstet. Gynec. 113:485, 1972.	311	22	7
11. Fisch et al, JAMA 222:1507, 1972.	7,605		1.2 to 2.8*
12. Smith, Am. J. Obstet. Gynec. 113:482, 1972.	2,053	19	1
13. Clezy et al, British Heart J. 34:1238, 1972.	74	3	4
14. Ramcharan et al, in "Oral Contraceptives and Blood Pressure" p. 1, 1974.	11,672	38	0.62*

* Age adjusted percentage

** 61 patients ingested Oracon; 60 ingested Ovulen, 71 ingested Norinyl and 75 Chlormadinone

approximately double that of the other two groups (13.9 per 1,000). During the three years of observation, an additional 6.2 per 1,000 women ingesting oral contraceptives became hypertensive while approximately 1 per 1,000 of the nonusers and the past users became hypertensive. An additional interesting finding was uncovered by this study. The incidence of development of hypertension during ingestion of oral contraceptive agents increased with increasing age. Women using oral contraceptives in the age range 40 to 44 were at approximately five times the risk of developing hypertension as those using oral contraceptives in the age range 30 to 34 and at approximately ten times the risk as those using oral contraceptives in the age range 25 to 29.² That age may be a significant cofactor in elevation of blood pressure accompanying ingestion of oral contraceptives has also been noted by others.³⁻⁵

These data may be contrasted with those of other investigators who failed to observe an elevation of blood pressure in users of oral contraceptive drugs.^{1 6 7} For example, Hall and Hatcher⁶ failed to observe development of hypertension (i.e. 140/90 mm Hg) in any of the 42 women studied while Weir et al⁷ observed significant elevations of both systolic (14 mm Hg) and diastolic (9 mm Hg) blood pressure in 83 Scottish women ingesting oral contraceptives for three years; however, elevations of pressure failed to reach the level regarded as hypertensive (140/90 mm Hg). The results of prospective studies by other investigators are cited in Table 1. If it is assumed that the incidence of elevation of blood pressure in women ingesting oral contraceptive agents is in the range found in the Walnut Creek study² (approximately 6 per 1,000 greater than in a population of nonusers), large numbers of subjects would be

required to find statistically significant effects. It is not surprising, therefore, that small samples such as Hall and Hatcher's⁶ with only 42 women had no cases in which blood pressure became elevated. It is more surprising that other investigators with similar sized, or slightly larger, groups have reported measurable incidences of elevation of blood pressure. It seems likely that a number of unidentified factors exist within an apparently randomly distributed population that may influence development of hypertension in users of oral contraceptive drugs. Since no information exists as to the mechanism of their interaction with oral contraceptive drugs, we shall refer to them as cofactors.

An example of one such cofactor is age as previously discussed. This cofactor has not been controlled in some studies and could influence the outcome.

Other cofactors may exist. For example, Woods et al⁸ studied 14 women previously normotensive who developed hypertension while ingesting oral contraceptives. After withdrawal of the drug, blood pressures returned to the normotensive range within six months. A follow-up of these patients revealed that half remained normotensive while the remaining half again became hypertensive even though oral contraceptives had been withdrawn. Of the 14 women studied, nine had at least one hypertensive parent and in the case of two others both parents were hypertensive. Woods et al⁸ suggest that use of oral contraceptives may hasten the onset of hypertension in those women predestined to become hypertensive because of their genetic constitution. Indeed, laboratory studies with rats suggest that the development of hypertension was hastened when an oral contraceptive agent was administered to them during the initial stages of development of either the genetic⁹ or renal type¹⁰ of experimental hypertension.

Another potential cofactor has been suggested. Some investigators feel that a correlation may exist between development of hypertension during ingestion of an oral contraceptive and a history of toxemia during a previous pregnancy.¹¹⁻¹⁴ The assumption is that the hormonal environment present during pregnancy is similar to that present during oral contraceptive therapy. However, this correlation between toxemia and development of hypertension during oral contraceptive therapy is debated by others.^{15,16} The converse of this has also been suggested; viz, those who become hypertensive on oral contraceptives and have not experienc-

ed a previous pregnancy are more likely to suffer toxemia when pregnancy is undertaken. There is no hard evidence to support this suggestion.

An additional cofactor suggested by some investigators may be race. Thus, the study of Saruta et al¹², which reports one of the highest percentages of initially normotensive women on oral contraceptives subsequently developing hypertension (10 of 56), also included one of the highest percentages of black women (17.8%). The fact that black women have higher blood pressures than white women when compared at similar age ranges may be an important interacting factor that requires further study.¹⁷ The report of Weir et al⁷ on Scottish women is also of interest since it suggests that a subset of the white race may be more resistant to the development of hypertension during oral contraceptive therapy than the white population at large. A significant number of the 83 women studied had an elevation of systolic and diastolic blood pressure during oral contraceptive therapy. However, none became hypertensive (140/90 mm Hg).

An additional cofactor that may interact with oral contraceptives is preexisting renal disease. Although an association has been suggested in a few individual cases,¹⁸⁻²¹ other studies using larger numbers of subjects failed to confirm the association.^{16, 22, 23} Spellacy and Birk²³ studied the effect of a variety of contraceptive methods on the blood pressures of 78 hypertensive women for one year. The subjects received no antihypertensive drugs during this time. There was no change in blood pressure with the use of an intrauterine device. Administration of either a combination-type oral contraceptive or two different progestogen minipills was accompanied by a decrease in blood pressure. These investigators concluded that essential hypertension is not an absolute contraindication to the use of oral contraceptive agents.

Other cofactors, as yet unknown, certainly exist and contribute to elevation of blood pressure in women ingesting oral contraceptive agents. Hopefully, these additional cofactors will be isolated as this area is studied further.

Although there is disagreement among investigators with regard to incidence of development of hypertension in oral contraceptive users, there seems to be little doubt that chronic ingestion of an oral contraceptive can elevate blood pressure in certain susceptible women. For example, Laragh et al⁵ studied 11 women, six of whom were known to have been normotensive prior to ingesting oral

contraceptives. Blood pressure became elevated in eight of 11 patients. In six of the eight patients who stopped oral contraceptive therapy, blood pressure was reduced. In two of this group, after return of blood pressure to the normal range, a second round of oral contraceptive therapy was instituted. Blood pressure became elevated in both cases a second time. Thus, there seems to be little doubt that the elevation of blood pressure in these two women was associated with administration of the oral contraceptive agent. A number of other reports have confirmed the fall in blood pressure of hypertensive, oral contraceptive users following withdrawal of the drug.^{8, 15, 24}

Since the type of oral contraceptive most commonly used is the combination drug containing both an estrogenic and a progestational agent, the question naturally arises as to which component of the pill is responsible for elevation of blood pressure. Spellacy and Birk²⁵ studied the effects of estrogens alone (mestranol, ethinyl estradiol, and conjugated estrogens) or progestogens alone (medroxyprogesterone acetate, norgestrol and ethynodiol diacetate) on blood pressure of women during six months of therapy. Control subjects employed an intrauterine device for contraceptive purposes. Within each group, the incidence of elevation of diastolic blood pressure (>90mm Hg) above that observed in the control group at the end of six months of treatment was 11% for those ingesting mestranol, 7% for those ingesting ethinyl estradiol, and 7% for those ingesting conjugated estrogens. The women ingesting the progestogens failed to have elevations in their blood pressure during this time. Thus, it would appear that the hypertensive component of the oral contraceptive drug may be associated with the estrogenic agents contained in them.

The mechanisms by which oral contraceptives may induce hypertension in certain susceptible women are not clearly understood. An early observation of Helmer and Griffith²⁶ in rats provided a significant clue. These investigators reported that administration of estrogens to rats was accompanied by an increase in the renin substrate concentration of blood. It has been shown subsequently that administration of estrogenic agents also stimulates hepatic production of a number of other plasma proteins in addition to renin substrate. The list is large and includes thyroxine binding proteins as well as glucocorticoid binding proteins. The observation of Helmer and Griffith²⁶ was confirmed in women ingesting oral contraceptives by a number of investigators.^{5, 7, 12, 15} Renin,

produced by the juxtaglomerular apparatus of the kidney, combines in the blood with renin substrate to form angiotensin I, a decapeptide (Fig. 1). Angiotensin I is converted to angiotensin II, an octapeptide, largely by a converting enzyme present in the lung. When compared on an equimolar basis, angiotensin II is the most potent vasoconstrictor produced by the body. It also stimulates the adrenal cortex to secrete the mineralocorticoid hormone, aldosterone.

Production of renin by the kidney is stimulated when either blood pressure or blood volume is reduced and when either plasma sodium or potassium concentration falls (Fig. 1). Stimulation of *B*-adrenergic receptors in the kidney can also stimulate secretion of renin by the juxtaglomerular cells.²⁷⁻³¹ The system appears to be influenced by several feedback control loops (Fig. 1). An increased blood concentration of angiotensin II can decrease production of renin by the kidney (short feedback loop)^{28, 32} while increased sodium and water retention induced by increased blood concentration of aldosterone as a consequence of increased blood angiotensin II concentrations can also feed back on the juxtaglomerular cells to reduce renin secretion. This is designated as the long feedback loop. If an increase in plasma renin concentration is initiated by a fall in blood pressure, the peripheral vasoconstriction induced by angiotensin II would also serve as a feedback loop to reduce renin secretion. Although not as yet integrated into any of the above feedback mechanisms, it is worth emphasizing that either reduction in *B*-adrenergic outflow to the kidney or reduction in *B*-adrenergic responsiveness (*B*-adrenergic antagonists) can also reduce renin secretion.^{27, 29}

A number of investigators have shown that women chronically ingesting oral contraceptives containing estrogens have measurable increases in plasma renin substrate concentration, plasma renin activity, and plasma aldosterone concentration while plasma renin concentration is decreased.^{33, 34} These observations led Saruta et al¹² to suggest that those women who become hypertensive during ingestion of an oral contraceptive agent may have a defective short feedback loop which when functioning properly, would decrease renin secretion as angiotensin II levels of the blood increased and consequently would reduce angiotensin II levels of the blood (negative feedback). Those women with defective feedback mechanisms would have an elevated blood renin concentration in addition to elevated levels of renin

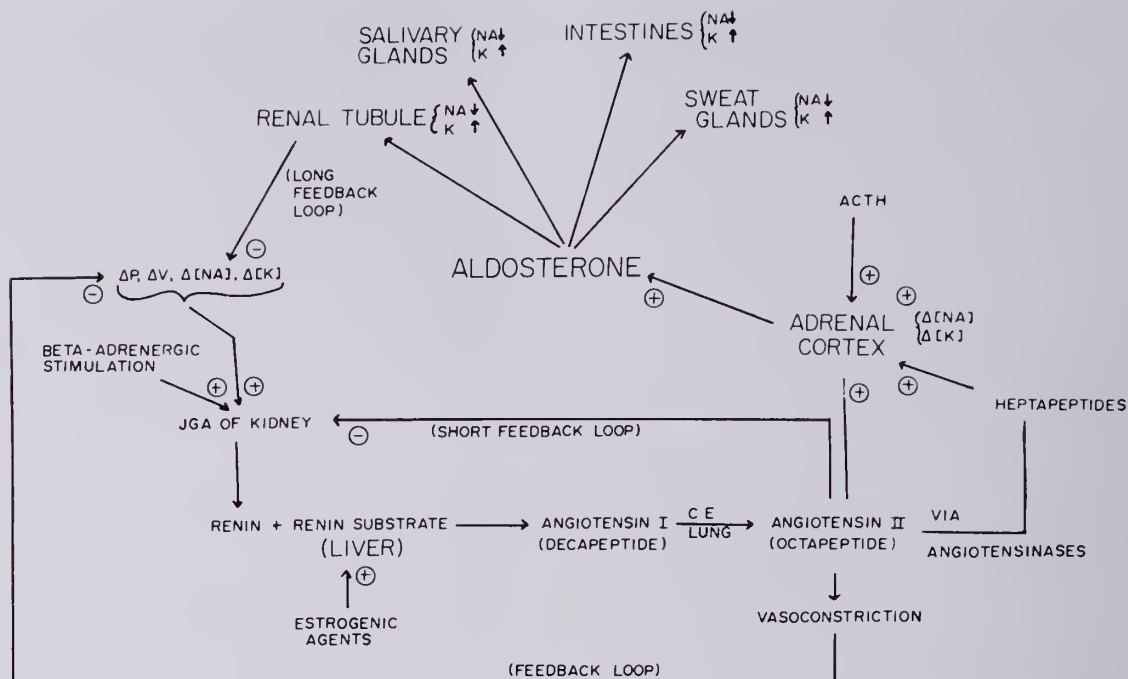


Fig. 1.—A schema for control of aldosterone secretion is shown. A decrease in transmural pressure, in blood volume or plasma sodium concentration, as well as a decrease in plasma potassium concentration, sensed at the level of the juxtaglomerular apparatus and macula densa (sodium only), stimulate secretion of renin into blood. Renin combines with renin substrate (formed by the liver) to produce the decapeptide, angiotensin I. Estrogenic agents are known to stimulate production of renin substrate by liver. Conversion of angiotensin I to angiotensin II occurs mainly in the blood vessels of the lung by a converting enzyme. Angiotensin II stimulates the adrenal cortex to produce aldosterone which is responsible for sodium reabsorption and potassium loss in renal tubules, salivary glands, intestines and sweat glands. Rising blood levels of angiotensin II also feed back on the juxtaglomerular cells of the kidney to inhibit secretion of renin (short feedback loop) and the resistance vessels of the body to increase blood pressure and decrease vascular capacity. Retention of sodium, loss of potassium, and increase in plasma volume as a result of an increase in aldosterone secretion rate characterizes the long feedback loop. Rate of secretion of aldosterone by the adrenal cortex is known to be increased by pituitary ACTH as well as by direct effects of reduced plasma sodium and increased plasma potassium concentrations.³⁵ The half-life of angiotensin II in blood is governed by the presence of angiotensinase enzymes which inactivate angiotensin II. One of the metabolites, angiotensin heptapeptide, can stimulate adrenal cortical secretion of aldosterone but has no significant vasoconstrictor properties.

substrate, angiotensin II, and aldosterone. The hypertension developing in these women could then be attributed theoretically to elevated plasma levels of angiotensin II and aldosterone.

This appealing notion has been difficult to prove. Beckerhoff et al³⁶ and Cain et al³⁷ have shown that women who did not become hypertensive on oral contraceptive agents and who had a 50% reduction in plasma renin concentration still had a three-fold increase in plasma renin activity and plasma aldosterone concentration. Thus, a three-fold rise in plasma renin activity and plasma aldosterone concentration is consistent with normotension. Other possibilities have been suggested to account for these facts. An increase in the rate of metabolism of angiotensin II by

angiotensinases in blood may occur in those women who do not become hypertensive while ingesting oral contraceptives (Fig. 1.). This would serve the function of decreasing the biological half-life of angiotensin II. However, a defective angiotensin metabolism in women who become hypertensive while ingesting oral contraceptive agents has yet to be documented.

It is now clear that the original hope of many investigators that the renin-angiotensin-aldosterone system might be useful as a screening device for predicting those women who would develop hypertension on oral contraceptives has limited usefulness.

Recent studies from the authors' laboratory have shown a reduced responsiveness to B-

adrenergic stimulation in estrogen-treated rats.⁴⁸ Since one of the functions of the *B*-adrenergic system is to reduce peripheral resistance, reduced responsiveness in estrogen-treated rats could leave the *a*-adrenergic (vasoconstrictor) system unopposed and could contribute to the elevation of blood pressure observed in rats administered an estrogenic agent.^{10, 49-51}

Whether a similar reduced *B*-adrenergic responsiveness exists in humans administered estrogenic agents is unknown at present. If it does, it may have an important bearing on interpretation of the mechanism for the reduction of renin concentration in the blood of oral contraceptive-treated women. Thus, those women who show reduced *B*-adrenergic responsiveness would be expected to show a reduction in their plasma renin concentration since the usual contribution of the *B*-adrenergic system to plasma renin secretion would be absent (Fig. 1). In contrast, those women who fail to develop a reduced *B*-adrenergic responsiveness during oral contraceptive therapy would maintain higher blood levels of renin with a consequent elevation in blood concentrations of angiotensin II and aldosterone. Although this possibility is appealing, hard data regarding both *B*-adrenergic secretion and responsiveness in women during oral contraceptive administration are not yet available.

It seems clear that a single mechanism for production of hypertension in certain susceptible women ingesting oral contraceptive agents cannot be cited. Multiple changes occur. Whether hypertension develops in a given individual depends on the magnitude of the increase in cardiac output, the degree of change in peripheral resistance, body water, extracellular and vascular volumes, the interaction of the renal and adrenal cortical systems, and the responsiveness to, and secretion of, catecholamines and other endogenous pressor agents. One must also be aware of the fact that the interaction of estrogens with other endogenous hormones, e.g. oxytocin, may alter vascular responses from vasodilatory to vasoconstrictor.⁵² This interesting observation has not been extended to either oral contraceptive-treated laboratory animals or humans.

It is also clear that a great deal more study is needed both to understand the mechanisms by which estrogenic hormones may elevate blood pressure and to devise reliable tests to determine the susceptibility of women ingesting oral contraceptives to elevation of blood pressure.

Several other mechanisms require consideration. Estrogens are well known to have a

direct effect on the heart (Fig. 2). Actomyosin content of the heart can be increased by administration of estrogenic agents to rats and can be decreased by ovariectomy.³⁸ Rubin³⁸ reported that certain steroids of the estrogen and pregnane series produced augmented function in isolated frog hearts made hypodynamic by reducing their calcium content. In addition, Loynes and Gowdey⁴⁰ studied the effects of sodium estrone sulfate and Premarin on hypodynamic frog hearts and reported a significant augmentation of function without an effect on rate. The effect of these estrogenic agents on augmentation of function in hypodynamic rabbit hearts was less striking although greater effects were seen on augmentation of coronary flow than on augmentation of function. Thus, estrogens may exert a beneficial effect directly on the heart, particularly the hypodynamic heart.

Walters and Lim⁴¹ showed in their first study that administration of an oral contraceptive containing both an estrogenic and progestational agent to six young women, 19 to 27 years old, was accompanied by an increased cardiac output (dye dilution technique), cardiac index, mean blood pressure and plasma volume during two to three months of therapy. Diastolic pressure and heart rate were not affected significantly. In a second study on 30 women 18 to 30 years old, the same findings were again reported.⁴² Littler et al⁴³ measured pulmonary blood flow and cardiac output by whole body plethysmography in 31 women, 12 of whom were receiving an estrogen-progestogen contraceptive agent; eight of whom were receiving a progestogen-only agent while 11 (control group) were using other methods of contraception or none. Mean cardiac output of the women ingesting the estrogen-progestogen contraceptive was significantly ($P < 0.01$) greater than the controls as was cardiac index ($P < 0.05$). The cardiac output and cardiac index of the progestogen only group did not differ from the control group. There were no differences among the groups with respect to pulmonary arterial distensibility, heart rate or systolic blood pressure. Hence, the increased cardiac output, resulting mainly from increased contractility rather than increased rate, may represent a direct effect of the estrogenic agent on the heart and may contribute to the elevation of blood pressure observed in women ingesting oral contraceptives. However, the increased cardiac output may also occur as a result of an increased venous return secondary to an increase in plasma volume and body water content.⁴⁴ This may be the consequence of increased plasma concentration of

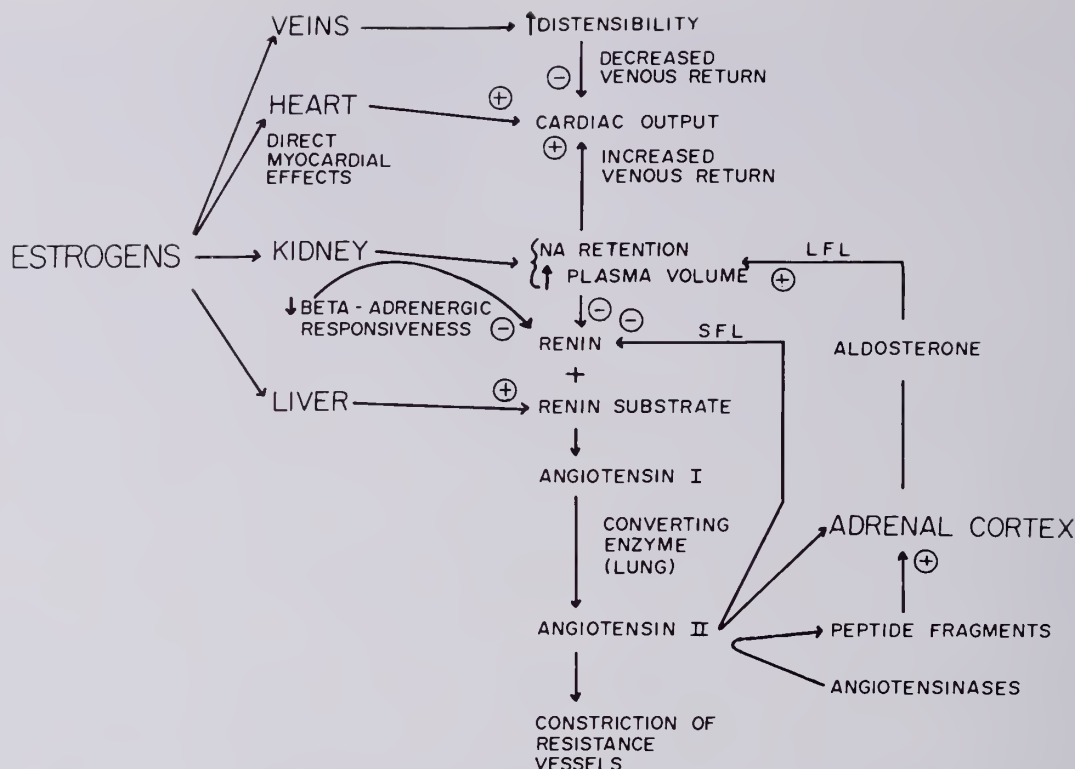


Fig. 2.—A schema suggesting some interactions of estrogenic agents in the control of blood pressure. Estrogens increase venous distensibility, increase cardiac output, induce sodium retention and increase plasma volume via the kidney, reduce responsiveness to *B*-adrenergic stimulation and increase hepatic production of renin substrate. Since cardiac output is increased in oral contraceptive users, it is apparent that the direct myocardial effects as well as the increased venous return dominate the increased venous distensibility. Sodium retention and increased plasma volume are induced by increased blood levels of aldosterone via the long feedback loop (LFL). Angiotensin II levels of the blood are increased as a result of increased plasma renin substrate concentration. Negative feedback of angiotensin II on renin secretion is via the short feedback loop (SFL) which has been postulated to be defective in those who become hypertensive during oral contraceptive therapy. A reduced *B*-adrenergic responsiveness, induced by estrogens, could also serve as a negative feedback limb to reduce renin release and angiotensin II levels of the blood.

aldosterone resulting in sodium and water retention. An aldosterone-like effect of estrogenic agents is also likely (Fig. 2). Johnson and Davis⁴⁵ showed that estrogenic agents manifested their sodium-retaining activity by a mechanism separate from that of mineralocorticoids since sodium retention occurred when estrogens were administered to dogs that were no longer responsive to the sodium-retaining effects of desoxycorticosterone (escape phenomenon).

The increase in cardiac output accompanying administration of oral contraceptives to women suggests a reason why most studies have found more prominent elevations in systolic than diastolic pressure. It also suggests that the effect of oral contraceptives may be manifest more on the heart and nervous system than on the peripheral vessels. In point of fact, considerable experimental evidence exists which indicates that estrogen administration increases venous distensibility rather than

decreasing it.^{46,47} Such an increase in venous distensibility, if present in women ingesting oral contraceptive agents, should reduce cardiac output (Fig. 2). Since cardiac output is increased, increased venous distensibility, if present, does not play a dominant role.

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Oral Contraception

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It has been 20 years since Rock, Pinkus, and Celso-Garcia described their first successful field trials in humans of what has become a common cliché, "The Pill".

Today there are approximately 10 million women in the United States and 50 million women in the world using one of the varieties of hormonal contraceptives available for fertility control. As stated in a report of an Advisory Committee to the Food and Drug Administration, "Never will so many people have taken such potent drugs voluntarily over such a protracted period for an objective other than for the control of disease."¹² There are 36 brands of oral contraceptives on the market today, and each physician, regardless of specialty choice, is considered an authority on reproductive matters.

Types

A. Combination

Pills which contain estrogen and progestin in each tablet. These pills are taken for three weeks and omitted for one week, during which time bleeding occurs. Some companies have marketed pills which are inert or contain iron to be taken during the week of bleeding so that the cycle will not be broken and a pill will be taken daily to assist the forgetful patient. The method effectiveness of the conventional combination agents is the best—one pregnancy per 1,000 women years.^{1 11 12}

B. Progestin alone (Mini-pill)

Continuous daily administration of a progestin alone. This type has a lower effectiveness rate than the combined, with a pregnancy rate of 2.5-3.7 per 100 women years. It has not achieved wide popularity because of unpredictable and irregular bleeding; however, for women who have estrogen-related side effects or other contraindications, the mini-pill may be useful as a contraceptive method.^{1 11 12}

Mode of Action

It has been demonstrated by a number of investigators that the oral contraceptives exert their action by inhibition of the hypothalamic-releasing factors thus blocking or interfering with gonadotropic secretion. FSH (Follicle Stimulating Hormone) secretion by the pituitary is decreased primarily by estrogen, and the progestin abolishes the mid-cycle-LH (Luteinizing Hormone) surge without affecting basal LH levels.¹¹

Choice of Dosage

A 50 mcgm. dosage of estrogen in a combined oral contraceptive appears to be the minimum dose necessary for consistent protection from pregnancy. Some compounds with lesser amounts of estrogen when combined with more potent progestin appear to provide protection from pregnancy equal to the 50 mcgm. pills.

If estrogen-related symptoms such as nausea or breast soreness are encountered in a patient taking 50 mcgm. combination pills, a small increase in risk of pregnancy encountered with patients taking one of the less than 50 mcgm. combined pills may be acceptable. In amenorrhea or symptoms of estrogen deprivation, a change to a combined pill with 80 or 100 mcgms. of estrogen may be required.^{19 12}

Side Effects

It has been estimated that 40% of women starting on the pill will experience unpleasant side effects, usually attributed to the estrogen. Most of these changes occur and subside within three months of usage.^{6 11}

A. Minor

1. Nausea and vomiting
2. Breakthrough bleeding
3. Psychic depression

May be increased in women taking oral contraceptives. The use of vitamin B₆

may reverse this side effect.¹⁶

4. Changes in weight
5. Alteration in menstrual flow and amenorrhea

The majority of patients on the combined pills experience reduction in the length and quantity of menstrual flow. Amenorrhea is encountered 4-6 per cent of cycles with incidence being slightly higher on the lower dose pills. If amenorrhea occurs in two consecutive cycles, pregnancy must be ruled out and pill usage reassessed.¹

6. Breast changes
A problem in the higher estrogenic pill.
7. Vaginitis
Monilial vulvo-vaginitis may occur, as during pregnancy, if persistent or recurrent, it merits a diabetic work up.¹¹

B. Major (In order of frequency)

1. Thromboembolic disease
Oral contraceptives have been proven to have a definite influence in the predisposition to thrombophlebitis. Women are more at risk with predisposing conditions such as hypertension, varicose veins, diabetes, obesity, chronic disease, cancer, advancing age, localized trauma or infection, surgery, prolonged immobilization of a limb, or a past history of vascular disorders. The annual death rate from embolism attributed to oral contraceptives is three per 100,000 users.^{1 3}
2. Hypertension
The elevation of blood pressure is probably due to some alteration in the renin-angiotensin mechanism and both the estrogen and progestin components appear to contribute to its production. Hypertension may develop at any time during the administration of the pill, and is usually promptly reversible upon discontinuation of the pill.¹³
3. Carbohydrate and lipid metabolic effects
A decrease in glucose tolerance has been observed in a significant

percentage of patients on oral contraceptives. For this reason pre-diabetic and diabetic patients should be carefully observed while receiving oral contraceptives, and in diabetes the insulin requirement may increase.¹⁴ An increase in triglycerides and total phospholipids has also been observed in patients receiving oral contraceptives. This may be harmful in women predisposed to arteriosclerosis.¹

4. Post-pill amenorrhea

Prolonged amenorrhea following pill usage has been reported in 1-2 per cent of users. It is more common with a history of irregular menses or oligomenorrhea prior to contraception. Oral contraceptives should be avoided in this group of women.⁴

5. Gallbladder disease

There is an increased risk of surgically confirmed gallbladder disease. The increased risk is less than one in 6,000.⁷

6. Hepatoma

There have been reports of benign hepatomas in women taking oral contraceptives though a causal relationship has not been established.²

Precautions

1. Complete medical history and physical examination

These should be performed prior to the initiation of oral contraceptives. The pre-treatment and periodic physical examination should include special reference to blood pressure, breasts, abdomen, and pelvic organs, including a cytologic smear. As a general rule, oral contraceptives should not be prescribed longer than one year without the examinations being repeated. There is no evidence that periodic interruption of therapy serves any useful purpose and may provide an unnecessary risk of pregnancy.

2. Pregnancy immediately following oral contraceptive usage

It is recommended that alternate methods of contraception be considered until regular cycles have been re-established prior to undertaking a planned pregnancy.¹

3. Breast feeding

Oral contraceptives given in the immediate postpartum period may interfere with the initiation of or the continuation of lactation.¹

4. Jaundice

Oral contraception should not be given to any patient with jaundice. Cholestasis and cholestatic jaundice are uncommon but if jaundice develops, the medication should be discontinued.¹¹

5. Age

The age of the patient constitutes no absolute limiting factor. Because of the possibility of risk of myocardial infarction increasing with age, the use of other forms of contraception should be discussed with the older contraceptive users. The excess risk of developing a fatal myocardial infarction is estimated to be 3.5 per 100,000 women years in age 35-39 and 27.6 per 100,000 women years in age 40-44.⁸ The death rate in pregnancy also increases with age, (71 per 100,000 live births in women age 35-39, and 124.1 per 100,000 age 40-44.¹

6. Carcinoma

The possible carcinogenicity of estrogens for the oral contraceptive user can neither be confirmed or refuted. There has not been an increase in breast cancer in users of oral contraceptives and the development of benign breast lesions appears actually to be reduced.³ There is no evidence that there is an increased risk to precancerous lesions.¹¹

7. Use in pregnancy

There appears to be an association between administration of progestins and progestin-estrogen combinations in pregnancy with increased risk of congenital anomalies. Even the short-term administration of progestins and progestin-estrogen combinations as a medical test of pregnancy by the production of withdrawal bleeding should not be used.^{5 10}

8. Laboratory studies

The following laboratory results may be altered by the use of oral contraceptives:¹⁵

- A. Thyroid function—increase in PBI and BEI and decrease in T₃ uptake values.
- B. Metyrapone test—reduced response

- C. Pregnanediol determination—decreased
- D. Glucose tolerance test—decrease in tolerance
- E. Serum folate values—decreased
- F. Serum lipid values—increase in triglycerides and phospholipids
- G. Hepatic function—increased BSP, retention and alteration in other indices of hepatic function
- H. Coagulation tests—increase in prothrombin, FACTORS VII, VIII, IX, X; Decrease in antithrombin III. Increase in Norepinephrine induced platelet aggregability.

Beneficial Effects

Oral contraceptives has two great advantages over all other forms of contraception: Its remarkable effectiveness and its general acceptability. The use of oral contraceptives is associated with certain risk, but they also produce certain psychological and medical benefits in addition to the reliability in the prevention of pregnancy. The psychological benefits include: The confidence that comes from having a method proven to be highly effective, the resultant freedom from fear from an unwanted pregnancy, and the multiple advantages which accrue to the use of a non-coitally related contraceptive method. Medical benefits of a physiological nature which have been found to occur with the use of the pill are as follows: (1) A decreased incidence of ovarian cysts, benign breast neoplasia, menstrual disorders, premenstrual syndrome, iron deficiency anemia, sebaceous cysts, and acne, (due to decreased sebum production with estrogen administration). (2) An improvement, in certain patients, of libido, and selected cases of endometriosis.

When attempting to establish the risk-versus the benefit ratio for any individual patient it is important to consider the positive aspects of the use of oral contraceptives as well as the known adverse affects.¹ Your patients need to be reminded that the morbidity and mortality associated with pregnancy well exceeds that attributed to oral contraceptives.⁶

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The Florida Physicians' Insurance Reciprocal license, which was approved on December 12, 1976, is being presented by State Insurance Commissioner Bill Gunter (center) to W. Harold Parham, D.H.A., Attorney-in-Fact for the Reciprocal and Executive Vice President of the Florida Medical Association (left), and James W. Walker, M.D., President of PIMCO, administrator for the FMA's new professional liability insurance program.

Vaginal and Cervical Cancers and Other Abnormalities Associated with Exposure *in Utero* to Diethylstilbestrol and Related Synthetic Hormones

Abstract: The subject of diethylstilbestrol (DES) exposure *in utero* has become a familiar subject to all physicians. The National Cancer Institute's Division of Cancer Control and Rehabilitation has prepared a monograph for physicians of patients who have been the victims of DES. The following is a summary of the recommendations for management of the patient in whom DES type drugs may have been taken by their mothers before their birth.

I. WHAT IS DIETHYLSTILBESTROL (DES)?

DES (Diethylstilbestrol or stilbestrol), a synthetic estrogen-type hormone, was first synthesized in the late 1930's. During the 1940's many physicians throughout the United States and other countries prescribed this substance for pregnant women. Several studies suggested that in complications of pregnancy such as bleeding, threatened miscarriage, or diabetes, this treatment improved salvage of fetus.

Although its use in pregnancy has been discontinued, DES remains a useful agent for certain menopausal symptoms, certain cases of carcinoma of the breast and prostate, and a few other clinical problems.

II. WHAT IS THE CANCER PROBLEM ASSOCIATED WITH *IN UTERO* EXPOSURE?

In 1971, Drs. Arthur L. Herbst, Howard Ulfelder and David Poskanzer at Massachusetts General Hospital and Harvard Medical School reported a link between maternal DES therapy during pregnancy and the later occurrence of clear-cell adenocarcinoma of the vagina in female offspring exposed to the drug *in utero*. This initial report was soon confirmed by others.

A Registry of Clear-Cell Adenocarcinoma of the Genital Tract in Young Females has been established by Dr. Herbst and Dr. Robert E. Scully with support from the National Cancer Institute and the American Cancer Society. It now contains varying amounts of data on almost 300 cases from the

United States and abroad. Registry address is MARP, Room 303, 5841 Maryland Avenue, Chicago, Illinois 60610.

The patients have ranged in age from 7 to 28 years at the time of diagnosis.

Documentation of exposure to DES-type hormones has been established in two-thirds of the fully investigated case histories. Of the vaginal adenocarcinoma cases, more than 80 percent are known to have been exposed to DES-type hormones.

Because DES-type hormones were not administered to some of the mothers of these cancer patients, factors other than maternal hormone administration also may play a role in the etiology of these cancers.

In all cases for which precise treatment dates are available, the drug was initiated before the 18th week of gestation. Dosages and duration of therapy varied widely. However, as little as 1.5 mg. DES administered daily throughout pregnancy was found in one case history to be associated with subsequent cancer in female offspring. Administration of the drug in varying amounts for a week or more during the first trimester also was associated with the subsequent development of cancer.

Cancers related to DES-exposure have not been reported in male offspring.

Although the exact number of pregnant women treated with DES or chemically similar compounds during pregnancy is unknown, it has been estimated to be as many as two million. The risk of developing adenocarcinoma in exposed females under 30 years of age *appears to be minimal*, in view of the large exposed population and the very rare incidence of the disease so far reported. However, as exposed females grow older, the incidence of cancer related to DES-type drugs may change.

III. NONCANCEROUS IRREGULARITIES

Most of the vaginal and cervical cancers in the exposed females are associated with

vaginal adenositis (the presence of glandular epithelium in the vagina). Benign adenositis is found histologically in over 97 percent of vaginal clear-cell adenocarcinomas, whether or not a history of DES-type drug exposure in utero is confirmed. Vaginal adenositis is rare in normal (unexposed) young women.

The results of examinations of females exposed *in utero* to DES-type drugs have been reported in several studies. More than a third of those females who were exposed to DES-type drugs in utero in the first four months of gestation have vaginal adenositis, and more than two-thirds have cervical ectropion (the presence of glandular tissue on the portio vaginalis of the cervix).

Other abnormalities seen in these examinations, such as transverse vaginal and cervical ridges, also may be associated with intrauterine exposure to DES-type drugs. These are described by a variety of names—hood, pseudopolyp, rim, collar, cockscomb cervix.

IV. IF THE PATIENT WAS EXPOSED TO DES-TYPE DRUGS, WHAT SHOULD BE DONE?

All asymptomatic girls who were exposed *in utero* should receive a thorough pelvic examination at *menarche* or if they have reached 14 years of age. Younger girls should be examined if they develop abnormal bleeding or discharge. Whenever prenatal exposure is probable, and there are symptoms of discharge, further investigation is *imperative*, regardless of the patient's age. This investigation should not be concluded until it is certain that no lesion is present.

Before the examination is undertaken, the entire procedure should be thoroughly discussed with the patient (and her mother or father if she is a minor). The examination should include inspection and palpation, Papanicolaou smear (cervix and vagina), and an iodine staining test of the entire cervix and vagina. Abnormal areas, including those that do not stain with iodine, should be biopsied. This procedure can be performed in the physician's office with small biopsy instruments and without significant discomfort.

For the very young patient who has symptoms that require investigation, anesthesia may occasionally be required before an examination. A small speculum permits adequate visualization of the vagina

without undue discomfort in younger patients.

With asymptomatic females, if adequate examination is not possible at the initial visit, vaginal tampons should be used for a few months to allow an adequate examination later without discomfort.

Colposcopy is a useful adjunct to this examination, but it is not essential. Utilizing its low power magnification to examine the vagina and cervix, the physician can identify areas of glandular tissue (adenositis) in the vagina or on the cervix. This identification permits directed rather than "blind" biopsies. Used in conjunction with the iodine staining test and selected biopsy, colposcopy permits precise recording of observed abnormalities and their appraisal at fixed intervals.

V. FOLLOWUP EXAMINATIONS

The patient exposed to DES-type drugs should be followed on a regular basis. After a normal initial examination, annual pelvic examinations with cervical and vaginal cytology and iodine staining are probably adequate. If any abnormalities are noted during the initial evaluation, more frequent followup examinations are suggested (every 3 to 6 months, depending on the severity of the findings).

VI. MANAGEMENT OF VAGINAL AND CERVICAL IRREGULARITIES OTHER THAN CLEAR-CELL ADENOCARCINOMA

Locally destructive measures such as cauterization, cryosurgery, or excision can be utilized if atypical changes such as marked squamous dysplasia or carcinoma *in situ* of vagina or cervix are found on biopsy.

Optimal management of nonmalignant lesions in females exposed to DES-type drugs in utero is uncertain. At the present time, no case has been reported in which vaginal adenositis has progressed to cancer under direct observation. Careful followup appears at present to be the most prudent approach to DES-exposed subjects without carcinoma.

There is no evidence to date indicating that use of oral contraceptives by the DES-exposed population would be undesirable. However, they add further hormonal variables to a complex situation.

The presence of adenosis is not a contraindication to future pregnancy if the woman desires to have children.

VII. CANCER DIAGNOSIS

The cancers from DES exposure have been found more often on the cervix or upper anterior vaginal wall. They usually are elevated, soft and friable, with a tendency to invade surrounding tissue early and metastasize through the lymphatic system. The ratio of vaginal to cervical site of origin (classification of the Cancer Committee of the International Federation of Gynecology and Obstetrics) has been approximately two to one.

VIII. CANCER THERAPY

Decisions regarding mode and extent of therapy in these young women are difficult and further complicated by emotionally charged issues. Both surgery and high energy radiotherapy potentially can cure the disease. Cancers associated with DES-type drugs may develop in young women primarily in tissues of Mullerian origin—the upper portion of the vagina and the cervix.

Treatment should be highly individualized and is best accomplished by physicians experienced in treating gynecologic cancers.

The following publications may be obtained at no cost from the National Cancer Institute's Office of Cancer Communication, Bethesda, Maryland 20014. (1) Information for Physicians-DES Exposure In Utero, (2)

Information for the Concerned Public—Questions and Answers About DES Exposure Before Birth, (3) Information for the General Public—Were You or Your Daughter Born After 1940.

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SPECIAL ARTICLES

Stress and Strain of a Medical Marriage

Thomas B. Thames, M.D.

When I first received the invitation to address the members of the Florida Medical Association Auxiliary at their Fall Conference in Daytona Beach on the particular problem of being married to a physician, I immediately went to the hospital library and checked the Cumulated Medical Index for information published on this subject in the past eight years. I was unable to find a single article relating specifically to divorce and medical marriages. Oh, it was easy to find a study that showed that the American divorce rate is now approximately 43% of marriages. It was easy to find studies showing physicians who build successful careers working 60 to 70 hours a week leaving themselves open to depression and suicidal tendencies. But there were no studies found showing actual rate of divorces for physicians or discussing the particular stress factors for physician marriages so I explained at the outset that all opinions expressed were personal ones related to my own ideas and practice and probably tinged with my own male chauvinism.

In considering the time in a professional life when divorce is most apt to occur, I think the incidence is not likely to be great in the first few years of marriage when the couple get married while the medical student is still in medical school. They have common goals and interests and are working together toward a successful completion of medical school. They share the same financial burdens, work long hours together, have mutual friends in the same category, and are still in the honeymoon period of being able to forgive and forget and work at adjusting to each other.

The time of internship and residency training is a more stressful time in the marriage. Frequently the couple is separated physically by on call schedules requiring one of them to be in the hospital

overnight for several nights each week. Overwork and too little sleep make the physician partner irritable and his idea of relaxation is apt to be a quiet night or weekend at home with his mate and possibly a few friends. His partner is apt to feel cooped up and want to go out with the mate and a constant adjustment must be made by each. Monetary demands, though not as severe in today's residencies, still limit the couple's entertainment and home recreation. In this time period, too, the earliest problem of education gap begins when the physician partner is in an accelerated daily educational process which throws him in constant contact with others of the opposite sex in the same or related fields. He suddenly finds others who relate to him through common work more closely than does his mate. In addition, the newness of his marriage may be wearing off and he finds a number of other partners available in the new environment and the new status of physician.

If the couple survives this period intact, as I think most do, then they go through another period of relative closeness with the advent of the physician entering practice. Frequently, they are both new to the partnership or association and, not rarely, to the particular town where practice begins. They again have the common bonds of working together to establish the practice and make new friends. The length of time this process takes varies greatly but extends frequently to the time of greatest stress in the medical marriage.

The time of greatest stress in the medical marriage is, I believe, when the physician has become successful. He is usually between 40 and 55 years of age, has established a successful practice, and is known socially and professionally by many in his town of residence. His daily contact with other health professionals and requirements for

continuing medical education have widened the gap in education from his spouse and their fields of common interest may have dwindled to few. He is now a successful doctor and meets many members of the opposite sex in his practice and professional life. He is looked up to and respected by men and women outside and within the medical field. His advice and opinion is sought on many subjects by many different people. His every wish in the office and hospital are promptly carried out without grumbling or dissent. It is easy under the circumstances for the physician to develop a "God" complex. It is difficult for him to adjust to being an ordinary guy at home and not to find instant obedience to his every request and thoughtful consideration of every comment he makes. He is in a period of male menopause frequently and has some worries about his sexual ability and whether he has missed anything in life. He and his wife are older but he finds himself suddenly very attractive to younger women and with adequate financial resources to allow him to have an affair if he desires. A physician has plenty of opportunity to conduct an affair if he wishes. He has a multitude of meetings he is always going to, in and out of town. He has night calls from needy patients and he routinely has a schedule that brings him home at different times each day for legitimate reasons. This is the time when a successful medical marriage requires the most work and cooperation on the part of both partners. If they make it through this period then the chances of divorce decrease considerably.

What can you do to make yours a successful medical marriage when many you know around you have not succeeded? Please make allowances for the answers since they are bound to reflect the male attitude.

First, you can continue your education so that you don't allow the education gap to exist. If you were in a medically related field when you married, keep up your association and continue to read your professional journals. Or, if you have already skipped too many years, consider a refresher course in your field. If neither of these is available to you, consider joining the hospital auxiliary, or Auxiliary to the Florida Medical Association, Cancer Society, etc. Ask your husband about his practice and listen when he wants to talk about his worries and problems. It shouldn't be necessary to say listen but don't repeat anything he says about a patient. Show interest in his work and pride when he is honored by being asked to present a paper or being elected an officer in one of his medical activities.

Patients, office workers, physiotherapists and

countless others are going to make your husband feel important every day of his professional life. Make sure you make him feel he is more important to you and the family than to anyone else. Establish guidelines for the children with both of you establishing the criteria and then both living with them. As a doctor's wife you know much of the discipline of the children will fall on you because of your husband's absence. Don't hold him up as the bogey man to punish the children when he comes home. Likewise, he should not undermine your authority by giving in to the children and upsetting the guidelines when he is home. Set guidelines you and the children can live with and change them only with mutual concurrence and commensurate with age and responsibility of the children.

Next, encourage your husband to take vacations away from the practice with you and the children and with you alone at times. It is easy to get caught up in the routine of a 60 plus hour work week and have little time to share things with the family that will help hold you together. Try to go with him when they have joint husband and wife medical functions and try to go with him to those out of town meetings. Spend some of the time at functions for the wives at the meeting and not all of it shopping or seeing the town while your husband is in the meeting.

; Do your best to establish and maintain a happy sex life for both of you. Remember, even though he may be exposed to lots of willing partners out there, most husbands are lazy and happy to stay with what they have, if it is exciting. Read the new sexual books that patients are discussing with your husband. Don't be afraid to experiment and try something new. Most of all, don't be afraid to discuss the sexual side of your life with your husband. Being able to discuss your needs and desires with each other is half way to solving a problem.

Try to be home when your husband is home. It is fine to have weekly bridge games with the girls or belong to a bowling league and certainly I have encouraged you to participate in medically related activities, but be sure these do not interfere in a significant way with those few hours you and your husband may have together. If he comes home frequently to find his wife isn't there when he expects her, he may find someone else who is willing to be with him anytime he says. Sharing time together is the cement that holds your marriage together in those times when you must be apart.

There are probably lots of other factors we could discuss together in considering the stress and

strain of a medical marriage and I hope you will discuss them with your spouse because the only solution to the problem is adequate communication between those most involved.

In conclusion, after discussing the stressful periods of marital life with a physician, I have suggested you recognize stress, have a honest

dialogue about it, try to develop some common interests, set goals together, arrange to be home when he is home, work on improving your sex life, and learn to communicate with each other.

● Dr. Thames, 1723 Lucerne Terrace, Orlando 32806

**Rows of blinking machines
Radiate the exhibit hall.
Lo, one stethoscope.**

**The research professors,
Arguing over statistical minutiae
Squander the meeting's time.**

**A variety of accents
Accent American medicine.
Scientific appeal/ money?**

**"Addressing" papers like:
Serum apolipoprotein patterns of normolipemic
subjects and patients with primary hyper-
lipoproteinemia
OR
Glucose-6-phosphatase deficiency monotypism in
atherosclerotic lesions of heterozygotes related to
lesion thickness.
I nod.**

**Hot day.
Thousands of thirsty cardiologists.
One cocktail waitress.**

Senryu composed by Dr. Charles G. Eschenburg of Delray Beach during the meeting of the American Heart Association in Miami Beach.

Stress and Strain of a Medical Marriage

From a Wife's Point of View

Lou Prather

The best insurance against stress and strain in the medical marriage is love. Dr. Thames has mentioned several areas that require the wife's special attention to maintain a viable husband-wife relationship. After briefly discussing some expectations of the institution of marriage I would like to conclude with comments on three areas that require the husband's attention.

The medical marriage should make a good wholesome family; but, good wholesome families have stress and strain. The question is will the stress and strain serve to make the unit stronger with more understanding and love or will it destroy the relationships within the family.

It has been wisely stated that women are responsible for 90 per cent of the homemaking. The book, "Family," by Margaret Mead and Ken Heyman, states there have been few and brief social deviations from this basic concept. This documentary on family styles throughout the world is good reading for anyone interested in the family unit.¹

Adela Rogers St. Johns defines society's high expectations of the family in her book, "The Honeycomb". She writes, "Throughout history, throughout all civilizations, a nation has been as strong and as sound and as happy as the Family. The Family is the foundation of the happiness we seek, the safety we long for, the love and the faith we have cherished. The First Unit. The man is the head of the house, but the foundation of the Family is the character and the joy of the mother."² There should be no social responsibility more cherished than the making and the keeping of this first unit in our social organization.

It may well be that the stress of the medical marriage is no greater than the stress of the nonmedical marriage. Stress and strain of the medical marriage may be a facade to cover up the real problem - a lack of love. This lack of love may be more specifically explained in terms of immaturity, adultery or selfishness. Love does not flourish in the presence of these handicaps. Love is not just an affair of the heart but also a state of mind. Love is an

accumulation of positive ideas about a person. One does not fall out of love but rather allows negative ideas to accumulate until there is no room for the positive ideas.

The first colony in Australia was made up of convicts from England. They were charged to go 'outback' and make farms. The men were not allowed to go back to England so it was just a matter of time before the business of mail-order brides was set up. The marriages were for the most part successful because each partner knew what was expected.³ In America we need to get back to our basic expectation of marriage. The goal cannot be defined as happiness; happiness in marriage is a by-product not a goal. Not only do children do better when they know what is expected of them but adults also function better when they know what is expected. Families know when they are functioning well together. There is satisfaction in knowing their resources are being used to the advantage of the family unit. Then and only then are they in a position to experience happiness. Here too is the right environment for love but the majestic quality of love is not limited to man's rationale. That brings us to the three areas that require the husband's special attention.

First, a man must love his wife. His decision to marry should be based on his ability to love this woman. He needs to do this for himself as well as for her. In truly loving a woman a husband puts her in a position to be a good homemaker. If a woman is mature enough to respect her husband his love will be returned to him in many delightful ways: a growing companionship, loving children, joy in each others presence, to name a few. Even the most talented woman cannot accomplish these things year in and year out in the absence of her husband's love. His love is a vital emotional support that keeps her giving and loving.

Second, the man must exercise his responsibility as the family breadwinner (and the wife must allow him to do so). Of course, the wife can lend a helping hand just as the husband helps clear off the table after dinner or helps in caring for the children. Her attitude must remain one of helping even if her income is greater than his, or if for some reason he is

Mrs. Prather is the wife of E. Charlton Prather, M.D., an Associate Editor of the Journal.

unable to work. If the wife helped put her husband through medical school she has no right to boastful pride; he really could have made it without a wife; it might have been easier and more fun.

Third, a man must lead his family in the worship of God. "God is Love." (I John 4:8) He is the source of life and love and our only comfort in death. The act of regular worship stabilizes many aspects of family life. In worshiping together the family begins to understand the kind of love that leads to maturity.

"Love is very patient and kind, never jealous or envious, never boastful or proud, never haughty or selfish or

rude. Love does not demand its own way. It is not irritable or touchy. It does not hold grudges and will hardly even notice when others do it wrong. It is never glad about injustice, but rejoices whenever truth wins out. If you love someone you will be loyal to him no matter what the cost. You will always believe in him, always expect the best of him and always stand your ground in defending him." (I Corinthians 13:4-7 in the Living Bible).

References

1. Margaret Mead and Ken Heyman, *Family*, New York, MacMillan and Company, 1965.
2. Adela Rogers St. Johns: *The Honeycomb*, New York, Signet The New American Library, 1970, p. 26.
3. Judson R. Landis: *Sociology: Concepts and Characteristics*, Belmont, Wadsworth Publishing Co., 2nd ed. p. 183.

If there is righteousness in the heart,
There will be beauty in the character.
If there is beauty in the character,
There will be harmony in the home.
If there is harmony in the home,
There will be order in the nation.
If there is order in the nation,
There will be peace in the world.

Chinese Proverb

It's Not the Quantity of Time, It's the Quality

Barbara Ann Keil

So, you're married to an M.D.!

Society puts him on a pedestal and, like it or not, you're put on one too! Someone else's wife is not likely to be introduced with reference to **his** occupation, but you're automatically Mrs. M.D.

This relationship of man and wife must extend into a professional partnership as well. You must be pleasant and patient at the gas station, grocery store, PTA meetings or on the phone, to present the image of your favorite physician. A genuine interest of his medical world, (when he wants to talk), helps keep you informed to the extent he desires (but you must never violate his confidence). Participation in the local or state medical auxiliary will be rewarding to you both, and glancing at a medical journal now and then can be quite enjoyable.

Time has become more precious than ever in our life time, and to the wife and family of a busy physician each hour must be used to its fullest. First, each one must accept the hours, weekends and holidays that the doctor must work; for unless he's **unhappy** at home, he surely isn't volunteering to spend that time away from home! Being sympathetic, understanding and keeping the family hum of activity going will be greatly appreciated, but don't fail to keep the bread winner informed so that he can participate in the family circle as much as possible. Clearing his calendar and planning around scheduled meetings, will enable him to join the family for fun and relaxation.

Secondly, when children are involved, be sure that they understand at an early age the demands made on their Dad's time. They, too, can help to make his homecomings more pleasant. If there are several children, try arranging a Saturday or Sunday when one child spends a few hours alone with Dad—eating at the local burger stand, biking or whatever is meaningful to the child and would be fun to share with a busy, busy Dad; those hours will be remembered by each of them as something very dear.

It isn't the quantity of time with a child, but rather the quality! Too, because that special Dad might not be able to get to the store, you can help him give the children those little surprises that will light up their eyes. Just buy them and let him

present them; he'll enjoy the role of "super-dad," and you will glow with the relationship that you've encouraged to grow, and be happy because you have made both of them happy.

A physician is thought of as well educated and it is natural for everyone to expect him to be well informed. But days may go by without the benefit of his reading the daily paper! He can be a better person and active citizen of the community if he has a helpful wife who will circle or clip interesting articles to share with him. And, if you wait for him to get those tickets to the ballet, jazz concert or whatever the two of you might enjoy—it might never come about. His thoughts are taken up with more urgent matters. But he does have the need for a change of pace, and his partner-in-marriage must help accept this responsibility.

A wise man once said: "If your husband invites you to go somewhere with him, go, 'cause otherwise he'll find someone else to take your place!" The medical meetings that husbands attend can be an excellent means of "catching up." The miles spent in travel enable you to think, share and say all those things that escape daily living. It gives you a chance to wear that sexy nightie you can't wear around the children and time to physically express and experiment like the true lovers that you must be to keep your marriage alive and zestful. If you must leave the children, you'll be better parents because of the separation! Making careful arrangements for care of the children will insure a more pleasant time away.

Communication is a key element in any relationship that is to survive. It is vital to the physician-husband and wife relationship. Misunderstandings are less apt to take place when we keep each other informed, and as parents it is necessary to agree on a common philosophy of raising and disciplining the children.

Today women are entering virtually every type of skilled labor and profession. What once was a concern of the physician's wife—that her husband worked among a great number of females—has expanded to a large proportion of wives! It becomes apparent that to hold a man you must utilize the same talents as to win a man! The well-groomed, interesting lady who once won his heart must remain!

Barbara Ann Keil is the maiden name of the wife of a well-known Florida physician.

Continue to grow with him. Follow your present interests or broaden into new areas. Find challenges to spark your outlet for creativity; this can lead easily into an avocation which can bring personal pleasure before and after children leave "the nest," and the demands on your time have slackened.

As the wife of an M.D. you are looked to for leadership in the community. This is an excellent way for you to develop and gain recognition as an individual, and for your husband to be represented as a part in your achievements. Everybody today

wants to do their own thing, and as a woman you are encouraged to do so and not live in the shadow of your husband. You can and should be your own person, but don't compete with your husband! Confine your interests to those hours when he's not free; he'll be proud of you and of what you do.

Be sure that you allow that physician-husband to be Number One in your eyes. For indeed you are the marriage mate, professional partner, mother and lover that he chose. If you want to remain his leading lady, let him know it!

Perfect Woman

She was a Phantom of delight
When first she gleamed upon my sight;
A lovely Apparition sent
To be a moment's ornament;
Her eyes as stars of Twilight fair;
Like Twilight's, too, her dusky hair;
But all things else about her drawn
From May-time and the cheerful Dawn;
A dancing Shape, an Image gay,
To haunt, to startle, and way-lay.

I saw her upon nearer view,
A Spirit, yet a Woman too!
Her household motions light and free,
And steps of virgin-liberty;
A countenance in which did meet
Sweet records, promises as sweet;
A Creature not too bright or good
For human nature's daily food;
For transient sorrows, simple wiles,
Praise, blame, love, kisses, tears and smiles.

And now I see with eye serene
The very pulse of the machine;
A Being breathing thoughtful breath,
A Traveler between life and death;
The reason firm, the temperate will,
Endurance, foresight, strength, and skill;
A perfect Woman, nobly planned,
To warn, to comfort, and command;
And yet a Spirit still, and bright
With something of angelic light.

William Wordsworth

When Griseofulvin is indicated...



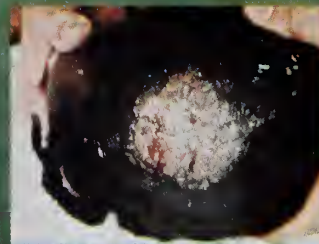
TINEA PEDIS*



TINEA UNGUIUM*



TINEA CRURIS*



TINEA CAPITIS*

*Also *Tinea barbae* and *Tinea corporis* when caused by fungi from genera known to be sensitive to griseofulvin.

Gris-PEG[®] (griseofulvin ultramicrosize) Tablets 125 mg offers effective therapy with 1/2 the dose.[†]

- Can be taken on an empty stomach
- Absorption nearly complete without fatty meals
- Reduced cost for patients
- Once-a-day or b.i.d. dosage

[†]250 mg of Gris-PEG[®] provides plasma levels equivalent to those obtained with 500 mg microsize griseofulvin. This improved absorption permits the oral intake of half as much griseofulvin but there is no evidence, at this time, that this confers any significant clinical difference in regard to safety or efficacy.



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LINCOLN, NEBRASKA 68501

Please see other side for full prescribing information.

Gris-PEG®

(griseofulvin ultramicrosize) Tablets
125 mg
The 1/2 dose griseofulvin.

DESCRIPTION

Griseofulvin is an antibiotic derived from a species of *Penicillium*.

Gris-PEG is an ultramicrocrystalline solid-state dispersion of griseofulvin in polyethylene glycol 6000.

Gris-PEG tablets differ from griseofulvin (microsize) tablets USP in that each tablet contains 125 mg of ultramicrosize griseofulvin biologically equivalent to 250 mg of microsize griseofulvin.

ACTION

Microbiology: Griseofulvin is fungistatic with *in vitro* activity against various species of *Microsporum*, *Epidermophyton* and *Trichophyton*. It has no effect on bacteria or other genera of fungi.

Human Pharmacology: The peak plasma level found in fasting adults given 0.25 g of Gris-PEG occurs at about four hours and ranges between 0.37 to 1.6 mcg/ml.

Comparable studies with microsize griseofulvin indicated that the peak plasma level found in fasting adults given 0.5 g occurs at about four hours and ranges between 0.44 to 1.2 mcg/ml.

Thus, the efficiency of gastrointestinal absorption of the ultramicrocrystalline formulation of Gris-PEG is approximately twice that of conventional microsize griseofulvin. This factor permits the oral intake of half as much griseofulvin per tablet but there is no evidence, at this time, that this confers any significant clinical differences in regard to safety and efficacy.

Griseofulvin is deposited in the keratin precursor cells and has a greater affinity for diseased tissue. The drug is tightly bound to the new keratin which becomes highly resistant to fungal invasions.

INDICATIONS

Gris-PEG (griseofulvin ultramicrosize) is indicated for the treatment of the following ringworm infections.

Tinea corporis (ringworm of the body)
Tinea pedis (athlete's foot)
Tinea cruris (ringworm of the thigh)
Tinea barbae (barber's itch)
Tinea capitis (ringworm of the scalp)
Tinea unguium (onychomycosis; ringworm of the nails)

when caused by one or more of the following genera of fungi:

Trichophyton rubrum
Trichophyton tonsurans
Trichophyton mentagrophytes
Trichophyton interdigitalis
Trichophyton verrucosum
Trichophyton megnini
Trichophyton gallinae
Trichophyton crateriform
Trichophyton sulphureum
Trichophyton schoenleinii
Microsporum audouinii
Microsporum canis
Microsporum gypsum
Epidermophyton floccosum

NOTE: Prior to therapy, the type of fungi responsible for the infection should be identified.

The use of the drug is not justified in minor or trivial infections which will respond to topical agents alone.

Griseofulvin is not effective in the following:

Bacterial infections
Candidiasis (Moniliasis)
Histoplasmosis
Actinomycosis
Sporotrichosis
Chromoblastomycosis
Coccidioidomycosis
North American Blastomycosis
Cryptococcosis (Torulosis)
Tinea versicolor
Nocardiosis

CONTRAINDICATIONS

This drug is contraindicated in patients with porphyria, hepatocellular failure, and in individuals with a history of sensitivity to griseofulvin.

WARNINGS

Prophylactic Usage: Safety and Efficacy of Griseofulvin for Prophylaxis of Fungal Infections Has Not Been Established.

Animal Toxicology: Chronic feeding of griseofulvin, at levels ranging from 0.5-2.5% of the diet, resulted in the development of liver tumors in several strains of mice, particularly in males. Smaller particle sizes result in an enhanced effect. Lower oral dosage levels have not been tested. Subcutaneous administration of relatively small doses of griseofulvin, once a week, during the first three weeks of life has also been reported to induce hepatoma in mice. Although studies in other animal species have not yielded evidence of tumor genesis, these studies were not of adequate design to form a basis for conclusions in this regard.

In subacute toxicity studies, orally administered griseofulvin produced hepatocellular necrosis in mice, but this has not been seen in other species. Disturbances in porphyrin metabolism have been reported in griseofulvin treated laboratory animals. Griseofulvin has been reported to have a colchicine-like effect on mitosis and cocarcinogenicity with methylcholanthrene in cutaneous tumor induction in laboratory animals.

Usage in Pregnancy: The safety of this drug during pregnancy has not been established.

Animal Reproduction Studies: It has been reported in the literature that griseofulvin was found to be embryotoxic and teratogenic on oral administration to pregnant rats. Pups with abnormalities have been reported in the litters of a few bitches treated with griseofulvin. Additional animal reproduction studies are in progress.

Suppression of spermatogenesis has been reported to occur in rats, but investigation in man failed to confirm this.

PRECAUTIONS

Patients on prolonged therapy with any potent medication should be under close observation. Periodic monitoring of organ system function, including renal, hepatic and hematopoietic, should be done.

Since griseofulvin is derived from species of *Penicillium*, the possibility of cross sensitivity with penicillin exists, however, known penicillin-sensitive patients have been treated without difficulty.

Since a photosensitivity reaction is occasionally associated with griseofulvin therapy, patients should be warned to avoid exposure to intense natural or artificial sunlight. Should a photosensitivity reaction occur, lupus erythematosus may be aggravated.

Griseofulvin decreases the activity of warfarin-type anticoagulants so that patients receiving these drugs concomitantly may require dosage adjustment of the anticoagulant during and after griseofulvin therapy.

Barbiturates usually depress griseofulvin activity and concomitant administration may require a dosage adjustment of the antifungal agent.

ADVERSE REACTIONS

When adverse reactions occur, they are most commonly of the hypersensitivity type such as skin rashes, urticaria, and rarely, angioneurotic edema, and may necessitate withdrawal of therapy and appropriate countermeasures. Paresthesias of the hands and feet have been reported rarely after extended therapy. Other side effects reported occasionally are oral thrush, nausea, vomiting, epigastric distress, diarrhea, headache, fatigue, dizziness, insomnia, mental confusion and impairment of performance of routine activities.

Proteinuria and leukopenia have been reported rarely. Administration of the drug should be discontinued if granulocytopenia occurs.

When rare, serious reactions occur with griseofulvin, they are usually associated with high dosages, long periods of therapy, or both.

DIAGNOSIS AND ADMINISTRATION

Accurate diagnosis of the infecting organism is essential. Identification should be made either by direct microscopic examination of a mounting of infected tissue in a solution of potassium hydroxide or by culture on an appropriate medium.

Medication must be continued until the infecting organism is completely eradicated as indicated by appropriate clinical or laboratory examination. Representative treatment periods are—*tinea capitis*, 4 to 6

weeks; *tinea corporis*, 2 to 4 weeks; *tinea pedis*, 4 to 8 weeks; *tinea unguium*—depending on rate of growth—fingernails, at least 4 months; toenails, at least 6 months.

General measures in regard to hygiene should be observed to control sources of infection or reinfection. Concomitant use of appropriate topical agents is usually required particularly in treatment of *tinea pedis*. In some forms of athlete's foot, yeasts and bacteria may be involved as well as fungi. Griseofulvin will not eradicate the bacterial or monilial infection.

An oral dose of 250 mg of Gris-PEG (griseofulvin ultramicrosize) is biologically equivalent to 500 mg of griseofulvin (microsize). USP (see ACTION Human Pharmacology).

Adults: A daily dose of 250 mg will give a satisfactory response in most patients with *tinea corporis*, *tinea cruris* and *tinea capitis*. One 125 mg tablet twice per day or two 125 mg tablets once per day is the usual dosage. For those fungal infections more difficult to eradicate such as *tinea pedis* and *tinea unguium*, a divided daily dose of 500 mg is recommended. In all cases, the dosage should be individualized.

Children: Approximately 5 mg per kilogram (2.5 mg per pound) of body weight per day is an effective dose for most children. On this basis, the following dosage schedule for children is suggested.

Children weighing over 25 kilograms (approximately 50 pounds)—125 mg to 250 mg daily.

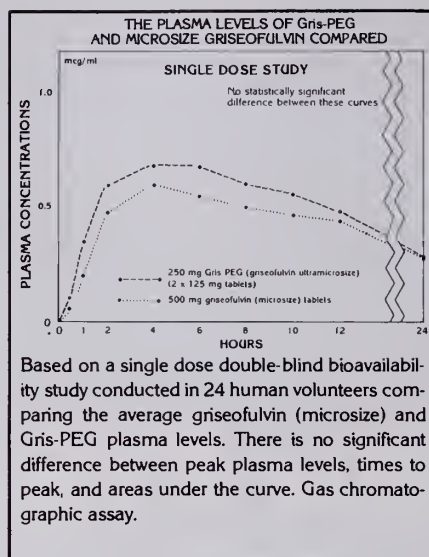
Children weighing 15-25 kilograms (approximately 30-50 pounds)—62.5 mg to 125 mg daily.

Children 2 years of age and younger—dosage has not been established.

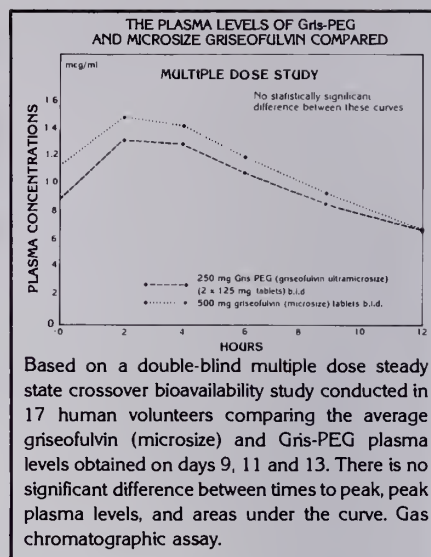
Dosage should be individualized, as is done for adults. Clinical experience with griseofulvin in children with *tinea capitis* indicates that a single daily dose is effective. Clinical relapse will occur if the medication is not continued until the infecting organism is eradicated.

HOW SUPPLIED

Gris-PEG (griseofulvin ultramicrosize) Tablets (white) differ from griseofulvin (microsize) tablets (USP) in that each tablet contains 125 mg of ultramicrosize griseofulvin biologically equivalent to 250 mg of microsize griseofulvin. Two 125 mg tablets of Gris-PEG are biologically equivalent to 500 mg of microsize griseofulvin. In bottles of 100 and 500 scored, film-coated tablets.



Based on a single dose double-blind bioavailability study conducted in 24 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels. There is no significant difference between peak plasma levels, times to peak, and areas under the curve. Gas chromatographic assay.



Based on a double-blind multiple dose steady state crossover bioavailability study conducted in 17 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels obtained on days 9, 11 and 13. There is no significant difference between times to peak, peak plasma levels, and areas under the curve. Gas chromatographic assay.

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I Cannot Tell A Lie—It Does Taste Like BANANAS!”

When acute, non-specific diarrhea causes the stomach to revolt, the tasteful counterattack is Donnagel®-PG. Donnagel-PG provides all the benefits of paregoric and—instead of that unpleasant paregoric taste—a delicious banana flavor good enough to make even an expert flip his wig.

Now with child-proof closure

Donnagel®-PG[©]

Donnagel with paregoric equivalent
For diarrhea

Each 30 ml. contains:

Kaolin	6.0 g.
Pectin	142.8 mg.
Hyoscyamine sulfate	0.1037 mg.
Atropine sulfate	0.0194 mg.
Hyoscine hydrobromide	0.0065 mg.
Powdered opium, USP	24.0 mg.
(equivalent to paregoric 6 ml.)	
(warning: may be habit forming)	
Sodium benzoate	60.0 mg.
(preservative)	
Alcohol, 5%	

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COUGHS ARE BACK



CLEAR THE TRACT

For coughs of colds,
"flu" and u.r.i.—
clear the tract

with the famous
Robitussin® Line!

The 5 members of the Robitussin® family all contain the expectorant, guaifenesin, to help clear the lower respiratory tract. Guaifenesin works systemically to help stimulate the output of lower respiratory tract fluid. This enhanced flow of less viscid secretions promotes ciliary action and makes thick, inspissated mucus less viscid and easier to raise. As a result, dry, unproductive coughs become more productive and less frequent.

For productive and unproductive coughs

Robitussin®

Each 5 ml teaspoonful contains:
Guaifenesin, NF 100 mg
Alcohol, 3.5%

For severe coughs

Robitussin A-C®

Each 5 ml teaspoonful contains:
Guaifenesin, NF 100 mg
Codeine Phosphate, USP 10.0 mg
(warning: may be habit forming)
Alcohol, 3.5%

Non narcotic for 6-8-hour cough control

Robitussin-DM®

Each 5 ml teaspoonful contains:
Guaifenesin, NF 100 mg
Dextromethorphan
Hydrobromide, NF 15 mg
Alcohol, 1.4%

Decongests nasal passages and sinus
openings as it helps relieve coughs

Robitussin-PE®

Each 5 ml teaspoonful contains:
Guaifenesin, NF 100 mg
Pseudoephedrine
Hydrochloride, NF 30 mg
Alcohol, 1.4%

Decongestant action helps control cough and
clear stuffy noses and sinuses. Non narcotic.

Robitussin-CF®

Each 5 ml teaspoonful contains:
Guaifenesin, NF 50 mg
Phenylpropanolamine
Hydrochloride, NF 12.5 mg
Dextromethorphan
Hydrobromide, NF 10 mg
Alcohol, 1.4%

All Robitussin formulations available on your
Rx or Recommendation.

For many years Robins has spotlighted the expectorant action of the Robitussin cough formulations by featuring action photographs of steam engines like the one on the preceding page. In keeping with this tradition, last year the company commissioned a well-known illustrator to render full-color drawings of several classic locomotives . . . accurate to the minutest detail. Chances are you requested and received the first locomotive in this series, The William Mason, last winter. Now, the second one is available. (See below). To order your print suitable for framing, write "Robitussin Clear-Tract Engine #2" on your Rx pad and mail to "Vintage Locomotives," Dept. T4, A. H. Robins Company, 1407 Cummings Drive, Richmond, Va. 23220.



The Davis Camel (1873)

OUR PHOTO: Norfolk & Western Branch Train
No. 202 west bound near Alvarado, Va. (Oct., 1956).
This line reaches the highest point of any railroad
west of the Rockies (elevation 3,577 ft.) with a
minimum grade of 3%. It crosses 108 bridges,
some 700 ft. long! Photo by O. Winston Link.

A-H-ROBINS

A. H. Robins Company, Richmond, Va. 23220

New Study Just Released!

Important information for physicians about generics

**Latest National Survey* Reports:
Pharmacists again prefer**

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Over every other generic manufacturer.

There are 5 major national drug manufacturers with generic lines: Purepac, Pfizer, Lederle, Parke-Davis and SmithKline, but only Purepac manufactures more of its generic products—in its own plants, than any of the other 4.

Purepac's is the most complete of all these national generic lines, and Purepac's prices are more economical.

Now that many states have repealed their anti-substitution law, you can help reduce your patients prescription costs with quality generics. Prescribe Purepac,

or request your pharmacists to dispense the Purepac brand.

Bio-availability data of Purepac manufactured pharmaceuticals and Generic Reference Chart are yours upon request.

*The November 1976 study by American Druggist Magazine reconfirms Purepac leadership over every other generic manufacturer.

Copies of this study, and Purepac's Annual Report are available.

Manufacturers of Fine Pharmaceuticals for Over 48 Years



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AMERICA'S LEADING NATIONAL BRAND OF GENERICS

**Brief Summary of
Prescribing Information**

Actions: Pyrvinium pamoate appears to exert its anthelmintic effect by preventing the parasite from using exogenous carbohydrates. The parasite's endogenous reserves are depleted, and it dies. Povan is not appreciably absorbed from the gastrointestinal tract.

Indication: Povan is indicated for the treatment of enterobiasis.

Warnings: No animal or human reproduction studies have been performed. Therefore, the use of this drug during pregnancy requires that the potential benefits be weighed against its possible hazards to the mother and fetus.

Precautions: To forestall undue concern and help avoid accidental staining, patients and parents should be advised of the staining properties of Povan. Care should be exercised not to spill the suspension because it will stain most materials. Tablets should be swallowed whole to avoid staining of teeth. Parents and patients should be informed that pyrvinium pamoate will color the stool a bright red. This is not harmful to the patient. If emesis occurs, the vomitus will probably be colored red and will stain most materials.

Adverse Reactions:

Nausea, vomiting, cramping, diarrhea, and hypersensitivity reactions (photosensitization and other allergic reactions) have been reported. The gastrointestinal reactions occur more often in older children and adults who have received large doses. Emesis is more frequently seen with Povan Suspension than with Povan Filmseals.

How Supplied: Each Povan Filmseal[®] contains pyrvinium pamoate equivalent to 50 mg pyrvinium, supplied in bottles of 50 (NDC 0710-0747-50; NSN 6505-00-134-1966). Povan Suspension, a pleasant-tasting, strawberry-flavored preparation containing pyrvinium pamoate equivalent to 10 mg pyrvinium per milliliter, is supplied in 2-oz bottles (NDC 0071-1254-31; NSN 6505-00-890-1093).

RC/RD PD-JA-1699-2-P (8-76)

When it's pinworms, treat the family



Povan[®] (pyrvinium pamoate)

- over 17 years of proved clinical effectiveness and safety
- no measurable absorption from the GI tract—minimal systemic side effects
- one dose—one time—that's all that's usually required
- two dosage forms: Tablets and Suspension—suitable for the entire family

Povan—there's a form for every member of the family.
PARKE-DAVIS

*medically
necessary*

TWO WORDS THAT MIGHT SAVE YOU A 2 A.M. CALL

Mrs. Gomez is frightened.

She has checked into an emergency room because of "a fluttering in her chest." Your examination indicates her palpitations are a drug reaction — prompted by the medication you've prescribed many times before.

The new Florida law requires your pharmacist to substitute a generic drug for your prescription unless you write "medically necessary."

And the substituted prescription could cause an untoward reaction that is both frightening and serious.

The generic may not have the same bioequivalency or bioavailability as the name brand.

The result is, your patient will not get the drug you knew would work. Your carefully considered drug choice is being replaced and, like Mrs. Gomez, your patients and your reputation pay the price.

With the generic, your patient may not get all or may get too much of the medication you prescribe. Or get an impure form of it. Or find it an incompatible vehicle.

The next time you write a prescription, be sure the drug you've ordered is the one your patient gets.

Write "medically necessary" and tell your pharmacist that you want the drug you specify.

Tell your legislator to change the law because it's changing the way you practice medicine, and your patients may suffer in the process.

Put control of medication
back in your hands.

Write your legislator.

C I B A



DOCTORS ARE TALKING ABOUT THE PRACTICAL WAY TO LOWER CHOLESTEROL

Choloxin® (sodium dextrothyroxine)

...d for good reasons. Diet alone doesn't always work. CHOLOXIN® (sodium dextrothyroxine) has proved itself to be an effective cholesterol lowering adjunct to diet in euthyroid, non-cardiac patients. It has undergone ten years of clinical trials and eight years of practice. The clinical trials consisted of 337 clinical studies involving over 3,000 hypercholesterolemic non-cardiac patients. It is among the most thoroughly evaluated drugs ever presented to physicians.

...actical, too, is the one-tablet-a-day dosage regimen. It encourages patient cooperation, and is economical for long-term therapy.

CHOLOXIN (sodium dextrothyroxine) lowers cholesterol 15% to 35%, and keeps it down with most patients. (*Data on file, Flint Laboratories*).

Interested in receiving more information about lipid lowering? Write us or contact your Flint representative. We'll be glad to supply you with a complete product portfolio and samples for your evaluation.

NOTE: See following page for full prescribing information.

AN IMPORTANT NOTE:

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.



FLINT LABORATORIES

DIVISION OF TRAVENOL LABORATORIES, INC.
Deerfield, Illinois 60015

Choloxin® (Sodium Dextrothyroxine)

Effectively Lowers Elevated Cholesterol With Convenient Once-A-Day Dosage

Four strengths 1, 2, 4, and 6 mg are available making the scored tablet regimen a flexible dosage system. And, for most patients, CHOLOXIN tablets offer once-a-day dosage.

CHOLOXIN® (sodium dextrothyroxine) Single-Tablet-A-Day Dosage Schedules

See prescribing information in package insert reproduced below.

	Starting Dosage	Increased Monthly by	Usual Maintenance	Maximal Recommendation
Adult Hypercholesterolemic	1.0-2.0 mg.	1.0-2.0 mg.	4.0-8.0 mg.	4.0-8.0 mg.
Pediatric Hypercholesterolemic	0.05 mg./kg. body weight	0.05 mg./kg.	0.1 mg./kg. body weight	4.0 mg.
Hypothyroid Cardiac	1.0 mg.	1.0 mg.	4.0 mg.	4.0 mg.

Choloxin® (Sodium Dextrothyroxine)

Description

CHOLOXIN (sodium dextrothyroxine) is the sodium salt of the dextrorotatory isomer of thyroxine. It is chemically described as D-3,5,3',5'-tetraiodothyronine sodium salt.

Actions

The predominant effect of CHOLOXIN (sodium dextrothyroxine) is the reduction of serum cholesterol levels in hyperlipidemic patients. Beta lipoprotein and triglyceride fractions may also be reduced from previously elevated levels.

Most of the available evidence indicates that CHOLOXIN (sodium dextrothyroxine) stimulates the liver to increase catabolism and excretion of cholesterol and its degradation products via the biliary route into the feces. Cholesterol synthesis is not inhibited and abnormal metabolic end-products do not accumulate in the blood.

Indications

This is not an innocuous drug. Strict attention should be paid to the indications and contraindications.

CHOLOXIN (sodium dextrothyroxine) is an antilipidemic agent used as an adjunct to diet and other measures for the reduction of elevated serum cholesterol (low density lipoproteins) in euthyroid patients with no known evidence of organic heart disease.

The drug is also indicated in the treatment of hypothyroidism in patients with cardiac disease who cannot tolerate other types of thyroid medication. Before prescribing, note the following: Results from a randomized clinical study have indicated a possible adverse effect when CHOLOXIN (sodium dextrothyroxine) is administered to a patient receiving a digitalis preparation. There may be an additive effect. This additive effect may possibly stimulate the myocardium excessively, in patients with significant myocardial impairment. CHOLOXIN (sodium dextrothyroxine) dosage should not exceed 4 mg per day when the patient is receiving a digitalis preparation concomitantly. Careful monitoring of the total effect of both drugs is important.

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Contraindications

The administration of CHOLOXIN (sodium dextrothyroxine) to euthyroid patients with one or more of the following conditions is contraindicated:

1. Known organic heart disease, including angina pectoris; history of myocardial infarction; cardiac arrhythmia or tachycardia, either active or in patients with demonstrated propensity for arrhythmias; rheumatic heart disease; history of congestive heart failure; and decompensated or borderline compensated cardiac status.
2. Hypertensive states (other than mild, labile systolic hypertension).
3. Advanced liver or kidney disease.
4. Pregnancy.

5. Nursing mothers.

6. History of iodism.

Warnings

CHOLOXIN (sodium dextrothyroxine) may potentiate the effects of anticoagulants on prothrombin time. Reductions of anticoagulant dosage by as much as 30% have been required in some patients. Consequently, the dosage of anticoagulants should be reduced by one-third upon initiation of CHOLOXIN therapy and the dosage subsequently readjusted on the basis of prothrombin time. The prothrombin time of patients receiving anticoagulant therapy concomitantly with CHOLOXIN therapy should be observed as frequently as necessary, but at least weekly, during the first few weeks of treatment.

In the surgical patient, it is wise to consider withdrawal of the drug two weeks prior to surgery if the use of anticoagulants during surgery is contemplated.

When CHOLOXIN (sodium dextrothyroxine) is used as thyroid replacement therapy in hypothyroid patients with concomitant coronary artery disease (especially those with a history of angina pectoris or myocardial infarction) or other cardiac disease, treatment should be initiated with care. Special consideration of the dosage schedule of CHOLOXIN (sodium dextrothyroxine) is required. This drug may increase the oxygen requirements of the myocardium, especially at high dosage levels. Treated subjects with coronary artery disease must be seen at frequent intervals. If aggravation of angina or increased myocardial ischemia, cardiac failure, or clinically significant arrhythmia develops during the treatment of hypothyroid patients, the dosage should be reduced or the drug discontinued.

Special consideration must be given to the dosage of other thyroid medications used concomitantly with CHOLOXIN (sodium dextrothyroxine). As with all thyroactive drugs, hypothyroid patients are more sensitive to a given dose of CHOLOXIN (sodium dextrothyroxine) than euthyroid patients.

Epinephrine injection in patients with coronary artery disease may precipitate an episode of coronary insufficiency. This condition may be enhanced in patients receiving thyroid analogues. These phenomena should be kept in mind when catecholamine injections are required in sodium dextrothyroxine-treated patients with coronary artery disease.

Since the possibility of precipitating cardiac arrhythmias during surgery may be greater in patients treated with thyroid hormones, it may be wise to discontinue CHOLOXIN (sodium dextrothyroxine) in euthyroid patients at least two weeks prior to an elective operation. During emergency surgery in euthyroid patients, and in surgery in hypothyroid patients in whom it may not be advisable or possible to withdraw therapy, the patients should be carefully observed.

There are reports that sodium dextrothyroxine in diabetic patients is capable of increasing blood sugar levels with a resultant increase in requirements of insulin or oral hypoglycemic agents. Special attention should be paid to parameters necessary for good control of the diabetic state in dextrothyroxine-treated subjects and to dosage requirements of insulin or other antidiabetic drugs. If sodium dextrothyroxine is later withdrawn from

patients who had required an increase of insulin (or oral hypoglycemic agents) dosage during its administration, the dosage of antidiabetic drugs should be reduced and adjusted to maintain good control of the diabetic state.

When either or both impaired liver or kidney function are present, the advantages of CHOLOXIN (sodium dextrothyroxine) therapy must be weighed against the possibility of deleterious results.

Usage in Women of Childbearing Age

Women of childbearing age with familial hypercholesterolemia or hyperlipemia should not be deprived of the use of this drug; it can be given to those patients exercising strict birth control procedures. Since pregnancy may occur despite the use of birth control procedures, administration of CHOLOXIN (sodium dextrothyroxine) to women of this age group should be undertaken only after weighing the possible risk to the fetus against the possible benefits to the mother. Teratogenic studies in two animal species have resulted in no abnormalities in the offspring.

Precautions

It is expected that patients on dextrothyroxine therapy will show greatly increased serum protein-bound-iodine levels. These increased serum PBI values are evidence of absorption and transport of the drug, and should NOT be interpreted as evidence of hypermetabolism; similarly, they may not be used for titrating the effective dose of CHOLOXIN (sodium dextrothyroxine). PBI values in the range of 10 to 25 mcg% in treated patients are common.

If signs or symptoms of iodism develop during CHOLOXIN (sodium dextrothyroxine) therapy, the drug should be discontinued.

A few children with familial hypercholesterolemia have been treated with CHOLOXIN for periods of one year or longer with no adverse effects on growth. However, it is recommended that the drug be continued in patients in this age group only if a significant serum cholesterol-lowering effect is observed.

Adverse Reactions

The side effects attributed to dextrothyroxine therapy are, for the most part, due to increased metabolism, and may be minimized by following the recommended dosage schedule. Adverse effects are least commonly seen in euthyroid patients with no signs or symptoms of organic heart disease; the incidence of adverse effects is increased in hypothyroid patients, and is highest in those patients with organic heart disease superimposed on the hypothyroid state.

In the absence of known organic heart disease, some cardiac changes may be precipitated during sodium dextrothyroxine therapy. In addition to angina pectoris, arrhythmia consisting of extrasystoles, ectopic beats, or supraventricular tachycardia, ECG evidence of ischemic myocardial changes and increase in heart size have been observed. Myocardial infarctions, both fatal and non-fatal, have occurred, but these are not unexpected in untreated patients in the age groups studied. It is not known whether any of these infarcts were drug related.

Changes in clinical status that may be related to the metabolic action of the drug include the development of insomnia, nervousness, palpitations, tremors, loss of weight, lid lag, sweating, flushing, hyperthermia, hair loss, diuresis, and menstrual irregularities. Gas-

trointestinal complaints during therapy have included dyspepsia, nausea and vomiting, constipation, diarrhea, and decrease in appetite.

Other side effects reported to be associated with CHOLOXIN (sodium dextrothyroxine) therapy include the development of headache, changes in libido (increase or decrease), hoarseness, tinnitus, dizziness, peripheral edema, malaise, tiredness, visual disturbances, psychic changes, paresthesia, muscle pain, and various bizarre subjective complaints. Skin rashes, including a few which appeared to be due to iodism, and itching have been attributed to dextrothyroxine by some investigators. Gallstones have been discovered in occasional dextrothyroxine-treated patients and cholestatic jaundice has occurred in one patient, although its relationship to CHOLOXIN therapy was not established.

In several instances, the previously existing conditions of the patient appeared to continue or progress during the administration of CHOLOXIN (sodium dextrothyroxine); a worsening of peripheral vascular disease, sensorium, exophthalmos, and retinopathy have been reported.

CHOLOXIN (sodium dextrothyroxine) potentiates the effects of anticoagulants, such as warfarin or Dicumarol, on prothrombin time, thus indicating a decrease in the dosage requirements of the anticoagulants. On the other hand, dosage requirements of antidiabetic drugs have been reported to be increased during dextrothyroxine therapy (see WARNINGS section).

Dosage and Administration

For adult euthyroid hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is 4 to 8 mg per day. The initial daily dose should be 1 to 2 mg to be increased in 1 to 2 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, if that dosage level is indicated to effect the desired lowering of serum cholesterol.

When used as partial or complete substitution therapy for levothyroxine in hypothyroid patients with cardiac disease who cannot tolerate other types of thyroid medication, the initial daily dose should be 1 mg to be increased in 1 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, preferably the lower dosage. The maximum in patients receiving digitalis therapy is 4 mg.

For pediatric hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is approximately 0.1 mg (100 mcg) per kilogram. The initial daily dosage should be approximately 0.05 mg (50 mcg) per kilogram to be increased in up to 0.05 mg (50 mcg) per kilogram increments at monthly intervals. The recommended maximal dose is 4 mg daily, if that dosage is indicated to effect the desired lowering of serum cholesterol.

If new signs or symptoms of cardiac disease develop during the treatment period, the drug should be withdrawn.

How Supplied

CHOLOXIN (sodium dextrothyroxine) is supplied in prescription packages of scored 1, 2, 4, and 6 mg tablets.



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DIVISION OF TRAVELER LABORATORIES, INC.
Oerfield, Illinois 60015

Temporarily

STOP

Unproductive Coughs

A new product that
temporarily stops the cough

Ryna-CTM

Syrup



EFFECTIVE FORMULA

- Codeine Phosphate10 mg
(Warning: May be habit forming)
- Pseudoephedrine Hydrochloride30 mg
- Chlorpheniramine Maleate 2 mg

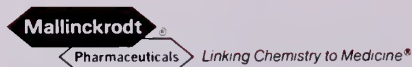
PATIENT BENEFITS

- Provides effective cough suppression
- Provides effective decongestant action
- Alleviates nasal secretions
- Dye-free formulation
- Sugar-free formulation
- Excellent cinnamon flavor

DOSAGE

ADULT—2 tsp every 4 hours
not to exceed 6 doses in 24 hours

PEDIATRIC—2-5 years ½ tsp every 4 hours
6-12 years 1 tsp every 4 hours
not to exceed 6 doses in 24 hours



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takes the place of adhesive tape

- Faster and easier to apply — methods are easily learned. "Difficult" bandaging areas become easy.
- The patient is more comfortable. No adhesive tape is needed; ordinary clothing — even shoes — can be worn over it.
- Free movement is not restricted. Workers get back on the job sooner.
- Dressings can be changed without changing bandage. Simply roll DRESSINET back, change dressing, and return DRESSINET to original position.
- Promotes faster healing by giving maximum aeration to the wound.
- The wound or dressing can be inspected without removing the bandage.
- Does not stick to wound or dressing.
- Does not restrict circulation.
- Much less expensive to use. Very little is needed for each bandage and it does not have to be changed with each dressing change.
- Non-allergenic.
- Can be sterilized by steam or gas, and can be re-used. DRESSINET has been autoclaved up to 20 times without affecting usability.

Size	Application
0	Finger, toe
1	Hand, foot
2	Elbow, knee
3	Shoulder, upper arm
4	Head, thigh
5	Thigh, hip, axilla
6	Chest, pelvis



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ORGANIZATION

Extra Credit Available at FMA Annual Meeting

Physicians attending the 103rd Annual Meeting of the Florida Medical Association will have a chance to pick up an extra hour of CME credit by participating in a University of Florida project.

The University of Florida Learning Resources Center is providing, through the specialty sections, a self-assessment questionnaire on drugs. It will cover current drug applications, indications covering all areas of cardiovascular disease, antianxiety agents, antipsychotic drugs and antibiotics.

Physicians may claim one hour of AMA Category 1 or FMA Mandatory Credit for completing the questionnaire. Results will be used to determine the content for a clinical pharmacology education program for the practicing physicians of Florida.

The credit is in addition to the 20 Category 1 hours previously approved for the sessions at the Americana Hotel in Bal Harbour, May 4-8.

Meanwhile, Wyeth Laboratories announced it would again provide at the Annual Meeting programmed instruction on several clinical subjects through teaching machines known as Autotutors. The machines will be available during scientific section hours, Thursday through Saturday, May 5-7.

Pfizer Laboratories for the second consecutive year will bring to the Annual Meeting four hours of "Dialogue," featuring guest speakers on topics to be announced later.

In addition to the Wyeth and Pfizer programs, there will be 36 scientific sections, including a Symposium on the Medical and Surgical Approaches to Stroke on Wednesday, May 4.

The stroke symposium will feature the following speakers:

- Peritz Scheinberg, M.D., Professor and Chairman, Department of Neurology, University of Miami School of Medicine, Miami
- Jesse E. Thompson, M.D., Professor of Surgery, University of Texas Southwestern Medical School, Dallas, Texas

—Hiram B. Curry, M.D., Associate Professor of Neurology and Professor and Chairman, Department of Family Practice, Medical University of South Carolina, Charleston, S.C.

Scientific programs in addition to those published previously in The Journal include:

FRIDAY AFTERNOON—MAY 6

SECTION ON OTOLARYNGOLOGY

(Co-sponsored by Florida Society of Otolaryngology)

Friday—2:00 p.m. to 5:00 p.m.

Herbert Fields, M.D., North Miami Beach
Program Chairman

Symposium on Medical and Surgical Treatment of Thyroid Disease

Moderator: Julian H. Groff, M.D., North Miami Beach

Panelists:

"Radiology in Thyroid Disease," Freddie P. Gargano, M.D.,

Chief Radiologist, Palmetto General Hospital, Hialeah

"Medical Evaluation of Thyroid Disease," Louis Chaykin, M.D., Endocrinologist, North Miami Beach

"Surgery of Thyroid and Parathyroid Glands," Julian H. Groff, M.D., ENT Surgeon, North Miami Beach

Coffee Break

Panel on Medical and Surgical Treatment of Sinus Disease

Moderator: Karl Morganstein, M.D., ENT Surgeon, Hollywood

Panelist:

"Radiology Diagnosis of Sinus Disease," Freddie P. Gargano, M.D., Chief Radiologist, Palmetto General Hospital, Hialeah

Adjournment

SECTION ON NEPHROLOGY

(Co-sponsored by Florida Society of Nephrology)

Friday—2:00 p.m. to 5:30 p.m.

Robert A. Metzger, M.D., Orlando

Program Chairman

A. Gorman Hill Memorial Lectureship—(Speaker to be Announced)

Symposium on When's and Why's of Renal Disease

"Renal Biopsy," Stephen I. Rifkin, M.D., Assistant Professor of Medicine, University of South Florida College of Medicine, Tampa

"Acute Renal Shutdown," J. Phillip Pennel, M.D., University of Miami School of Medicine, Miami

"Chronic Dialysis," William Way Anderson, M.D., South Florida Artificial Kidney Center, and Clinical Associate Professor of Medicine, University of Miami School of Medicine, Miami

"Renal Transplantation," William W. Pfaff, M.D., Professor of Surgery, University of Florida College of Medicine, Gainesville

Questions and Answers

Adjournment

SECTION ON PEDIATRICS

(Co-sponsored by Florida Chapter, American Academy of Pediatrics, and Florida Pediatrics Society)

Friday—2:00 p.m. to 5:30 p.m.

James A. Hallock, M.D., Tampa

Program Chairman

"Echocardiography," David G. Ruschhaupt, M.D., Division of Pediatric Cardiology, University Hospital, Jacksonville
"Approach to the Newborn with Heart Disease," Dolores Assistant Professor of Pediatrics, University of Miami School of Medicine, Miami

Break

"Rheumatic Fever, Elia M. Ayoub, M.D., Professor of Pediatrics, University of Florida College of Medicine, Gainesville

"Hypertension in Children," Robert Levin, M.D., Miami

Discussion

Adjournment

SATURDAY MORNING—MAY 7

SECTION ON OBSTETRICS AND GYNECOLOGY

(Co-sponsored by Florida Obstetric and Gynecologic Society)

Saturday—8:30 a.m. to 11:30 a.m.

John E. Startzman, M.D., Orlando

Program Chairman

Papers from the Department of Obstetrics and Gynecology, University of Miami School of Medicine

Papers from the Department of Obstetrics and Gynecology, University of South Florida College of Medicine

Papers from the Department of Obstetrics and Gynecology, University of Florida College of Medicine

Adjournment

SECTION ON OPHTHALMOLOGY

(Co-sponsored by Florida Society of Ophthalmology)

Saturday—9:00 a.m. to 10:30 a.m.

Nicholas H. Kalvin, M.D., Naples

Program Chairman

Selected Topics in Ophthalmology

Adjournment

SECTION ON DERMATOLOGY

(Co-sponsored by Florida Society of Dermatology)

Saturday—9:00 a.m. to 2:45 p.m.

Phillip Frost, M.D., Miami Beach

Program Chairman

Presentations by Residents in Dermatology at Mt. Sinai Medical Center, Miami Beach

Questions and Answers

"Application of Electron Microscopy to Clinical Diagnosis in Dermatology," Alvin S. Zelickson, M.D., Clinical Professor of Dermatology, University of Minnesota Medical School, Minneapolis, Minn.

Questions and Answers

"Surgical Treatment of Skin Cancer," Edward A. Krull, M.D., Chairman, Department of Dermatology, Henry Ford Hospital, Detroit, Mich.

Questions and Answers

Presentations by Residents in Dermatology at Mt. Sinai Medical Center, Miami Beach

Recess

CPC

Adjournment

Special Scientific Program Planned

For Auxiliary Meeting

The 49th Annual Meeting of the Florida Medical Association Auxiliary will feature a special scientific program sponsored by the FMA Committee on Continuing Medical Education.

Entitled "Cardiovascular Disease for the Doctor's Wife," the two and one half-hour program will begin at 3:00 p.m. on Friday, May 6, at the Americana Hotel in Bal Harbour.

Moderator will be Thomas B. Thames, M.D., of Orlando, President of the Florida Academy of Family Physicians and a member of the Executive Committee of the FMA Board of Governors.

Dr. Thames announced the following presentations:

3:00 p.m.—"Nutrition and Cardiovascular Disease," Yank D. Coble Jr., M.D., specialist in endocrinology and nutrition, and Chairman, FMA Committee on Continuing Medical Education, Jacksonville.

3:45 p.m.—"Physical Fitness and Cardiovascular Disease," Clarence H. Gilbert, M.D., Director of the Cardiovascular Catheterization Laboratory, Orange Memorial Hospital, Orlando.

4:30 p.m.—"Sexual Activity and the Cardiovascular Patient," Edward Spoto Jr., M.D., Associate Professor of Internal Medicine, University of South Florida College of Medicine, Tampa.

Dr. Thames said that while the program is primarily for members of the Auxiliary, spouses also are welcome.

(See Auxiliary annual meeting program next page)

FLORIDA MEDICAL ASSOCIATION AUXILIARY, INC.

ANNUAL MEETING — MAY 4 - 8 1977

AMERICANA HOTEL, BAL HARBOUR, FLORIDA

Daily Schedule of Meetings and Activities

WEDNESDAY, MAY 4, 1977

10:00 a.m. - 5:00 p.m. Registration for all State Officers, Chairmen and County Presidents
Pre-Registration for House of Delegates

11:00 a.m. - 5:30 p.m. Hospitality Room, Open

10:00 a.m. - 5:00 p.m. Tickets Available for Awards and FLAMPAC Luncheons - Registration Desk

11:00 a.m. Executive Committee Meeting — Suite of President, President Elect

10:00 a.m. - 2:30 p.m. Deliver At Show entries to booth in Exhibit Hall

1:00 p.m. Pre-Convention Board of Directors Meeting for ALL STATE OFFICERS, Chairman of Standing and Special Committees and County Presidents. ALL members are welcome as guests.

THURSDAY, MAY 5, 1977

8:00 a.m. - 5:30 p.m. VISIT HOSPITALITY ROOM AND THE ART SHOW IN FMA EXHIBIT HALL ALL ENTRIES BY FLORIDA DOCOTRS AND THEIR FAMILIES. HOSPITALITY ROOM WILL BE CLOSED DURING AWARDS LUNCHEON ON THURSDAY.

7:30 a.m. - 8:45 a.m. Complimentary Continental Breakfast for members of House of delegates

8:00 a.m. - 3:00 p.m. Registration of all officers, Standing and Special Committee Chairmen, County Presidents, Delegates, Members and Guests

9:00 a.m. - 12:00 noon First Session, House of Delegates Delegates please wear identifying badges and be seated with you delegation by 9:00 a.m.
Guest Speaker:
To Be Announced

12:00 noon Awards Luncheon — Luncheon honoring Past Presidents and new County Auxiliary, Presentation of Art Show Awards, Editor's Award from the Journal of the Florida Medical Association, Peggy Wilcox Trophy and Membership and AMA-ERF.

2:00 p.m. Second Session, House of Delegates Delegates wearing badges should be seated with their delegation by 2:00 p.m.
Memorial Service
County Presidents' Reports
Installation of 1977-1978 Officers

FRIDAY, MAY 6, 1976

7:30 a.m. - 8:30 a.m. Post Convention Auxiliary Board Meeting — Suite of President and President-Elect

8:30 a.m. - 5:00 p.m. Art Show — FMA Exhibit Hall

8:00 a.m. - 12:00 noon Hospitality Room

& 2:00 p.m. - 5:00 p.m. Closed during FLAMPAC Luncheon

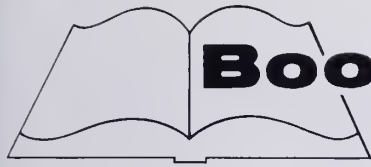
9:00 a.m. Post Convention Board of Directors Meeting — Orientation for all State Officers, Standing and Special Committee Chairmen, County Presidents, members and guests. Officers and Chairmen, please be ready to transfer files to new Board.

10:30 a.m. - 12:00 noon Guest Speaker:
To Be Announced

12:15 p.m. Auxiliary-FLAMPAC Luncheon
Guest Speaker:
To Be Announced

3:00 p.m. - 5:30 p.m. Panel on Physical Fitness — Moderator - Byron Thames, M.D.: (a credit course for professionals in the health fields)

6:30 p.m. - 7:30 p.m. FMA Cocktail Party — Poolside



Book Reviews

Book Review Editor

F. Norman Vickers, M.D.

Take Care of Yourself—A Consumer's Guide to Medical Care by Donald M. Vickery, M.D. and James F. Fries, M.D. 269 pages. Price \$5.95. Reading, Massachusetts, Addison-Wesley Publishing Company, 1976. (Paperback)

I had read a newspaper review of this book. In that review, it appeared that the authors took some sensational views such as questioning the sacredness and the effectiveness of the annual check up. Consequently, I reviewed the book with interest.

However, I failed to find much sensationalism in this book. It is written clearly, in everyday American language. The authors tell the readers that much of their health is in their own hands and caution against overeating, smoking, excess consumption of alcohol, drugs and foods. The authors give some realistic data about the limited effectiveness of the annual check-up and emphasize that early consultation for symptoms may be more advisable. Brief instructions are given about how to find the right physician and hospital. They point out that the use of the emergency room does not substitute for having a careful physician who knows the patient.

Two thirds of this book is devoted to specific complaints and conditions. This is designed to be used as a reference. For example, a brief description of the causes for heartburn is given. Home treatment is described. They advise avoiding irritants such as alcohol and aspirin, they advocate the use of antacids and measures to avoid a esophageal reflux.

Each section also includes a paragraph on "what to expect at the doctor's office." In the case of heartburn, they discuss the fact that medications to neutralize stomach acid will usually be given and medicines to reduce acid secretion. The authors point out that x-rays are usually not done on the

first visit and that any indication of bleeding will require a more vigorous approach to therapy and diagnosis. Algorithms are presented. If the reader follows the directions carefully, he will generally receive sound advice. One of the authors, Dr. Vickery, developed flow charts and manuals for the Army physicians-assistants training program.

In summary, this is a volume which gives generally sound advice. Unfortunately, like the Sunday sermon, those who need it most won't be present to get the message.

F.N.V.

Endoscopy by George Berci, M.D., 805 pages. Price \$78.00. Appleton-Century-Crofts, New York, N. Y. 1976.

When I saw the price of this book, I wondered how a single volume text could be marketed for \$78.00; however, the author, with the help of 58 co-authors, has pulled together various disciplines which use endoscopy: urology, neurosurgery, orthopedics, surgery and internal medicine. Chapters on sterilization of instruments, organization of the endoscopy room and training of endoscopy assistants will be of interest to every endoscopist reader. Chapters on the physics of endoscopy are highly technical and will be of major interest to bioengineers.

Only an endoscopic pioneer and innovator, such as Doctor Berci, could have put together such a book. It is recommended for medical libraries, especially in those centers having endoscopic trainees.

F. N. V.

Books Received

Receipt of the following books is acknowledged. Medical readers interested in reviewing particular books are invited to address requests to the Book Review Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.

Solved: The Riddle of Heart Attacks by Broda O. Barnes, M.D., Ph.D. and Charlotte W. Barnes, A.M. 84 Pages. Price \$2.50. Fort Collins, Colorado, Robinson Press, Inc., 1976.

Review of Medical Pharmacology, 5th Edition by Frederick H. Meyers, M.D., Ernest Jawetz, Ph.D. and Alan Goldfien, M.D. 740 Pages. Illustrated. Price \$12.50. Los Altos, California, Lange Medical Publications, 1976.

Correlative Neuroanatomy & Functional Neurology, 16th Edition by Joseph G. Chusid, M.D. 448 Pages. Illustrated. Price \$10.00. Los Altos, California, Lange Medical Publications, 1976.

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Coordinated Ambulatory Care, The POMR by Jefferson J. Vorzimer, M.D. 128 Pages. Price \$7.50. New York, Appleton-Century-Crofts, 1976.

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Medical News Around the State

Thad Moseley, M.D., of Jacksonville . . . a Past President of the Florida Medical Association, will assume the presidency of the 2,500-member Southeastern Surgical Congress in April.

The Congress's 45th anniversary assembly is expected to attract about 2,000 surgeons, specialized nurses and others to the Americana Hotel in Bal Harbour, April 3-7. Dr. Moseley will assume the gavel from J. Alex Haller, M.D., of Baltimore.

Associated with Jacksonville's Riverside Clinic, Dr. Moseley was President of FMA in 1974-75. Prior to that he served for several years as Editor of **The Journal of the Florida Medical Association.**

Robert Q. Marston, M.D., President of the University of Florida, will welcome the surgeons to Miami Beach. James R. Jude, M.D., and Robert Zeppa, M.D., both of the Miami arrangements committee, also will deliver welcoming remarks.



Dr. Moseley

Twenty-four Florida physicians . . . were inducted as Fellows of the American College of Chest Physicians during the group's 42nd Annual Scientific Assembly in Atlanta, Ga.

They are: Drs. Robert E. Bondurant and Thomas B. Williams, both of Pensacola; Charles R. Byrd, Dietmar Gann, and Paul S. Swaye, all of Miami Beach; Abraham Caplivski, Lauderdale Lakes; George F. Daviglus, Gerald A. Kaiser, Robert L. Reis, and Richard J. Thurer, all of Miami; and John B. Downs, Gainesville.

Drs. Allan L. Goldman, Victor J. Martinez, and Dennis F. Pupello, all of Tampa; Stanley S. Goodman, Ft. Lauderdale; Ira M. Jackler, Alan B. Miller, and Anibal A. Sanchez-Salazar, all of Jacksonville; Gholamali Meghdadi, Maitland; Victor R. Scarano, St. Petersburg; Robert B. Schader, South Miami; Thomas S. Shilen, Coral Gables; Abraham Szmukler, North Miami Beach; and William R. Welhaf, Boca Raton.

Gov. Askew has appointed . . . a 15-member Diabetes Advisory Council, including eight physicians.

Physician members of the Council are: E. Charlton Prather, M.D., Tallahassee, Director of the State Health Program Office; Robert V. Farese, M.D., University of South Florida College of Medicine, Tampa; Daniel H. Mintz, M.D., University of Miami School of Medicine; Arlan L. Rosenbloom, M.D., University of Florida College of Medicine, Gainesville; Eugene T. Davidson, M.D., Lakeland; Yank D. Coble, Jr., M.D., Jacksonville; Eugene M. Fierer, M.D., Miami; and Sanford N. Plevin, M.D., Dunedin.

Other members are: Mr. E. F. Keen, Jr., of Bradenton; Mr. Clifford Ables, a Sebring attorney; Mr. Martin Kahn, a Ft. Lauderdale attorney; Ms. Mildred Kaufman, Department of Health and Rehabilitative Services, Tallahassee; Ms. Patricia Schultz, Diabetes nurse specialist, Pensacola; Ms. Judy Jordan, Diabetes nurse specialist, Gainesville; and Mr. Robert Kronowitt, Executive Director of the Juvenile Diabetes Research Foundation, Miami.

Provision for the Council was contained in a bill passed by the Legislature to establish diabetes education, research and treatment centers in Florida.

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ACCREDITED BY THE J. C. A. H.



Letters to the Editor

To The Editor: Some time ago, Dr. F. Norman Vickers wrote to you and asked, under the Laws of Florida, what medical conditions are reportable?

Generally, ethical and legal doctrines recognize the confidentiality of communications between a physician and his patient. Indeed, Section 458.16, Florida Statutes, provides as follows, and is predicated on the confidentiality doctrine:

"Any doctor or other practitioner of any of the healing sciences making a physical or mental examination of, or administering treatment to, any person, shall upon request of such person, his guardian, curator, or personal representative in the event of his death, furnish copies of all reports made of such examination or treatment. Such reports shall not be furnished to any person other than the patient, his guardian, curator, or personal representative, except upon the written authorization of the patient; provided, however, that nothing herein shall prevent the furnishing of such reports without such written authorization, to any person, firm or corporation who with the patient's consent shall have procured or furnished such examination or treatment, and where compulsory physical examination is made pursuant to Rule 1.360, Florida Rules of Civil Procedure, copies of the medical report shall be furnished both the defendant and the plaintiff."

(Emphasis supplied)

While there has been little case law construing this specific statute, a number of exceptions seem to be generally accepted. It has been held by Florida

Appellate Courts that a physician has the right to communicate with his attorney regarding treatment of a patient when such treatment is the subject or anticipated subject of an eventual claim.

A more specific exception to the confidentiality doctrine lies in Section 381.231, Florida Statutes. This law requires certain communicable diseases to be reported to the Division of Health of the Department of Health and Rehabilitative Services. The section appears to be a clear exception to the requirement of Section 458.16, Florida Statutes, requiring patient approval prior to release of this kind of medical information. Subsection (4) of Section 381.231, Florida Statutes, provides:

"Information submitted in reports required by this Section is confidential and shall be made public only when necessary to public health. No report so submitted shall be considered a violation of the confidential relationships between practitioners and patient."

(Emphasis supplied)

The specific diseases reportable have been promulgated by rules of the Division of Health and are attached for your information.

I trust this information will be helpful.

John E. Thrasher
FMA Legal Counsel

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Commentary

Clinical Notes

1976 Postgraduate Obstetric-Pediatric Seminar

Jorge Deju, M.D.

Application of modern technology to the patient considered a high risk pregnancy is expensive but the possible alternative is maintaining a brain-damaged child all its life in a state institution at a cost of hundreds of thousands of dollars. Thus, Dr. John L. Duhring of Lexington, Ky., concluded his assessment of the high risk fetus. He reminded physicians attending the 26th annual Postgraduate Obstetric-Pediatric Seminar in Miami Beach that currently available technology also greatly reduces the severity of certain high risk conditions such as diabetes and hypertension.

Continuing, Dr. Duhring, who is Professor and Director of the Department of Obstetrics at the University of Kentucky Medical Center, stated that maternal urinary estriol excretion provides an accurate index of the placenta's metabolic function. Once normal values have been established for a particular laboratory it is possible to ascertain the fetus' intrauterine status and predict fetal death 72 hours in advance. If estriol excretion is high, then neither fetal nor neonatal death is encountered. In the marginal values stillbirth is not a problem but neonatal morbidity and mortality are encountered in the intermediate values.

Oxytocin-challenge testing, a type of fetal monitoring, allows measurement of the placenta's respiratory function. Human and animal experimentation has shown that decreased oxygenation of the fetus causes certain specific changes in the heart tracing. With oxytocin-challenge tests every week beginning at the 35th week, it is possible to predict when the placenta is suffering from respiratory failure and/or the fetus is having hypoxic problems. The test is simple and safe and requires very little time.

Evaluation of amniotic fluid defines precisely whether the fetus is mature. By such definition of maturity, it is possible to predict which babies will encounter neonatal problems and which will not. Particularly useful have been amniotic fluid creatinine and amniotic L/S ratios. If these tests show maturity then one can be confident that the fetus is mature and will not encounter morbidity when delivered and placed in the newborn nursery.

In high risk pregnancy patients estriol collections are begun at 32 weeks and oxytocin-challenge testing at 35 weeks. Using these two parameters it is possible to insure that intrauterine death will not occur. Beginning at 35 weeks amniotic fluid is periodically sampled and maturity of the fetus is ascertained. In this way the best time for a delivery may be scientifically defined when the risk of morbidity is at a minimal point.

Following Dr. Duhring, Dr. Donald V. Eitzman of Gainesville reviewed the clinical entity, neonatal necrotizing enterocolitis, and described results of a prospective controlled trial which showed that prophylactic use of oral kanamycin in small premature infants prevented the disease. The study was conducted at the University of Florida College of Medicine and a description of the research appears in the September 1976 Journal of Pediatrics. Dr. Eitzman is professor and director of the College's Division of Neonatology.

Organization of Florida's Regional Neonatal Intensive Care Center Program administered by the Children's Medical Services Program Office, Department of Health and Rehabilitative Services, was described by Dr. Edmund A. Egan, Associate Professor of Pediatrics at the University of Florida College of Medicine. He pointed to the program as particularly committed to statewide planning to avoid dupli-

Dr. Deju is Medical Administrator, Personal Health Programs, Health Program Office, Tallahassee.

cation of facilities and evaluation of results of intensive care of newborns, utilizing mortality rates and long-term developmental follow-up of survivors.

Role of the physician in the processes of planning perinatal health care was addressed by Dr. Gerold L. Schiebler of Gainesville, professor and chairman of the Department of Pediatrics at the University of Florida College of Medicine. Dr. Schiebler stated that quality health care depends upon health professional organizations and individual health professionals so that their professional judgment is involved in its planning, implementation, and evaluation.

Dr. Clifford H. Cole of Jacksonville stressed the increasing importance of screening for syphilis and gonorrhea in pregnancy. Approximately 80% of women with gonorrhea are asymptomatic and in general clinic populations 4% to 5% of patients screened have positive cultures. A repeat culture within seven to 14 days following treatment is essential considering that 20% of women treated for gonococcal cervicitis will otherwise be found to be

infected again within 30 days of therapy. Male sex partners should be treated simultaneously. A single test for syphilis or gonorrhea is inadequate to protect mother and infant from infection. A very high percentage of these infections occur during the last trimester and high risk patients should be retested routinely late in pregnancy.

Dr. Cole has been administrator of the Health Program Office Venereal Disease Control Program.

This year's Seminar, attracting 173 physicians, was presented by the U.S. Public Health Service, and Bureaus of Maternal and Child Health of the State Health Department of Alabama, Florida, Georgia, Kentucky, Mississippi, North and South Carolina, and Tennessee. It was accepted for credit by the Florida Medical Association's Continuing Education Committee and by the Florida Academy of Family Physicians.

► Dr. Deju, Department of Health and Rehabilitative Services, 1323 Winewood Boulevard, Tallahassee 32301.

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Anne Colston Wentz, M.D.
Psychogenic Amenorrhea and Anorexia Nervosa

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Disordered Function of the Corpus Luteum

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Joseph W. Goldzieher, M.D.
Polycystic Ovarian Disease

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Dysfunctional Uterine Bleeding

Pituitary Disorders

William H. Daughaday, M.D.
Sheehan's Syndrome

Bernard Kliman, M.D.
Pituitary Tumors

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Multiphasic Health Screening Centers

In 1972 the subject of multiphasic health testing was called to the attention of the health care industry in an article published by the American Medical Association. It is one method of initial health data acquisition, either automated, nonautomated or both. A physician must evaluate and interpret the test results otherwise this form of health testing becomes ineffective.

In the November 22nd, 1976 issue of the A.M.A. news a comprehensive feature article dealing with this subject appeared. As a result, organized medicine is already acquainted with certain concepts dealing with this subject.

This is a rapidly growing industry throughout urban America; it is estimated that at least one new center opens each week and attracts people by advertising multiple forms of health testing including blood chemistries, electrocardiograms, simple visual and auditory tests and pap smears, for approximately \$26 to \$30.

Here in Florida the centers already operating are doing so by obtaining an occupational license in the city in which it operates. There has been a conflict, now resolved, between organized medicine and the owners of the centers for various reasons, including "practicing without a license," failure to inform the patient that these tests do not replace a physician's history and physical examinations and, at times, advertisements that promised more than the centers could possibly deliver.

Approximately four weeks ago I met with the president of the National Association of Health

Testing Centers and we were able to work out an agreement that protects the public. It is my intention to introduce legislation in April to regulate health testing centers under a new Florida statute. The bill will include a definition of the center's medical director who will either be a medical doctor or osteopath and the director will be responsible for the interpretation of all tests and electrocardiograms to include his signature. There will be a multiphasic health screening advisory council consisting of five members including a medical doctor, an osteopath, a clinical laboratory director, a representative of the industry and a consumer.

All future advertisements will contain the statement, "health screening tests are not a substitute for a physician's examination but can alert you and your doctor to a serious medical problem which may exist if an abnormal test is reported." If all tests are normal, the client will be told that this does not rule out possible hidden disease.

It is my opinion that the steps outlined above, if carried out, will do a great deal to improve the image of the individual practitioner and organized medicine in Florida.

David J. Lehman, M.D.
Vice-Chairman
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MEETINGS

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FEBRUARY

South Florida Psychiatric Society Annual Symposium, Feb. 12, Dupont Plaza Center, South Miami*

Winter Management (Anesthesiology), Feb. 12-19, Miami*

Mease Hospital Tumor Board, Feb. 17, Mease Hospital, Dunedin. For information: Paul S. Berger, M.D., 725 Virginia Street, Dunedin 33528.

Psychopharmacology for the Internist, Family Practitioner and Private Psychiatrist, Feb. 18-19, Dutch Inn, Lake Buena Vista. For information: Barry E. Sieger, M.D., 1416 South Orange Avenue, Orlando 32806.

Ear Surgery: Microsurgery in 3-D, Feb. 20-24, Host Airport Hotel, Tampa+

Pediatric Dermatology Seminar, Feb. 24, Konover Hotel, Miami Beach. For information: Guinter Kahn, M.D., 16800 N.W. 2nd Avenue, N. Miami Beach 33169.

Recent Advances in Cardiopulmonary Care III, Feb. 25-26, Holiday Inn, Lido Beach, Sarasota. For information: Robert E. Windom, M.D., 1901 Arlington Street, Sarasota 33579.

Clinical Gastroenterology '77, Feb. 25-26, Dutch Inn, Lake Buena Vista. For information: Barry E. Sieger, M.D., 1416 South Orange Avenue, Orlando 32806.

Diagnostic Therapeutics, Feb. 26-27, Bahia Mar Hotel, Ft. Lauderdale. For information: M. J. DeAlmeida, M.D., 4330 West Broward Blvd., Ft. Lauderdale 33317.

Basic Neurology for Psychiatrists, Feb. 28-Mar. 4, Miami*

5th Annual Workshop on Methods of Analysis and Principles of Instrumentation in the Clinical Laboratory, Feb. 28-Mar. 4, Tampa+

MARCH

Medical Knowledge Self-Assessment Course, Mar. 2, 9, 16, 30, Borland Medical Library, Jacksonville. For information: JHEP, 655 W. 8th St., Jacksonville 32209.

Infectious Diseases 1977—Treatment and Prevention, Mar. 3-4, Cedars of Lebanon Health Care Center, Miami. For information: Ms. Thelma MacGregor, Seminar Coordinator, Box 520793, Miami 33136.

Third Annual Pediatric Surgical Postgraduate Course, Mar. 3-5, Americana Hotel, Miami Beach. For information: William T. Brown, M.D., Chief, Department of Surgery, Variety Children's Hospital, 6125 S.W. 31st St., Miami 33155.

Selected Topics in Urology, Mar. 3-5, Hilton Hotel, Gainesville**

Postgraduate Seminar in Dermatology, Mar. 4-6, Miami*

Skin 1977: What Every Nurse Should Know, Mar. 4-6, Miami*

Pediatric Anesthesia Seminar—Spring Cruise, Mar. 5-15, Miami*

3rd Annual USF Cancer "Tumors of the Genitourinary Tract," March 5, Tampa+

Mediclinics, Mar. 7-18, Galt Ocean Mile Hotel, Fort Lauderdale. For information: Walter J. Glenn, M.D., 1106 E. Broward Blvd., Fort Lauderdale 33301.

Annual Suncoast Trauma Seminar, March 9-11, University of South Florida, Tampa+

A Symposium in Gynecologic Endocrinology and Infertility, March 10-12, Hyatt House, Orlando. For information: B. Cantor, M.D., P.O. Box 13284, University Sta., Gainesville 32604

Basic Medical Hypnosis, Mar. 13-19, Miami*

Gynecologic Oncology Seminar, Mar. 15-26, Cruise*

Tenth Anniversary JHEP Instructional Course on Surgery of the Hand, March 16-20, Amelia Island. For information: Ira M. Dushoff, M.D., 580 W. 8th St., Jacksonville 32209. Neurology for Non-Neurologist V: Movement Disorders, March 17, Tampa+

Mease Hospital Tumor Board, March 17, Mease Hospital, Dunedin. For information: Paul S. Berger, M.D., 725 Virginia Street, Dunedin 33528.

Seventh Annual Special Radiological Procedures Seminar, Mar. 19-22, Konover Hotel, Miami Beach.*

Fifteenth Annual Clinical Radiology Seminar, Advances In Cancer Diagnosis, Mar. 22-26, Konover Hotel, Miami Beach.*

9th Teaching Conference in Clinical Cardiology, Mar. 23-26, Sheraton-Four Ambassadors Hotel, Miami.*

8th Annual Topics in Internal Medicine, Mar. 24-26, Hilton Hotel, Gainesville**

*For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152, Tel. (305) 547-6716.

**For Information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143.

+For Information: Contact Theron A. Ebel, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2074.

Cardiology, March 25-27, Contemporary Hotel, Lake Buena Vista. For information: Jonathan O. Partain, M.D., 1131 South Orange Avenue, Orlando 32806.

Post-Conventional Seminar, Pathologic-Radiologic Correlations, Mar. 26-29, Caribbean Cruise.*

2nd Annual Vail Conference in Respiratory Therapy, Mar. 26-Apr. 2, Miami*

Pulmonary Infection, Pulmonary Infarction (Embolus), Mar. 26-27, Tampa.+

Hepatitis: Diagnosis and Management, Mar. 31, Tampa.+

Frontiers in Ultrasound, Mar. 31-Apr. 2, Konover Hotel, Miami Beach. For information: Mrs. June Allen, Conference Coordinator, Mt. Sinai Medical Center, 4300 Alton Road, Miami Beach 33140.

APRIL

Infectious Disease and Chemotherapy for the Practicing Physician, Apr. 1-2, Hyatt House, Kissimmee. For information: Barry E. Sieger, M.D., 1416 S. Orange Ave., Orlando 32806.

Medical Knowledge Self-Assessment Course, Apr. 6, 13, 20, 30, Borland Medical Library, Jacksonville. For information: JHEP, 655 W. 8th St., Jacksonville 32209.

Cardiology Update—1977, Apr. 8-9, Sheraton Inn, Jacksonville Beach. For information: JHEP, 655 W. 8th St., Jacksonville 32209.

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Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

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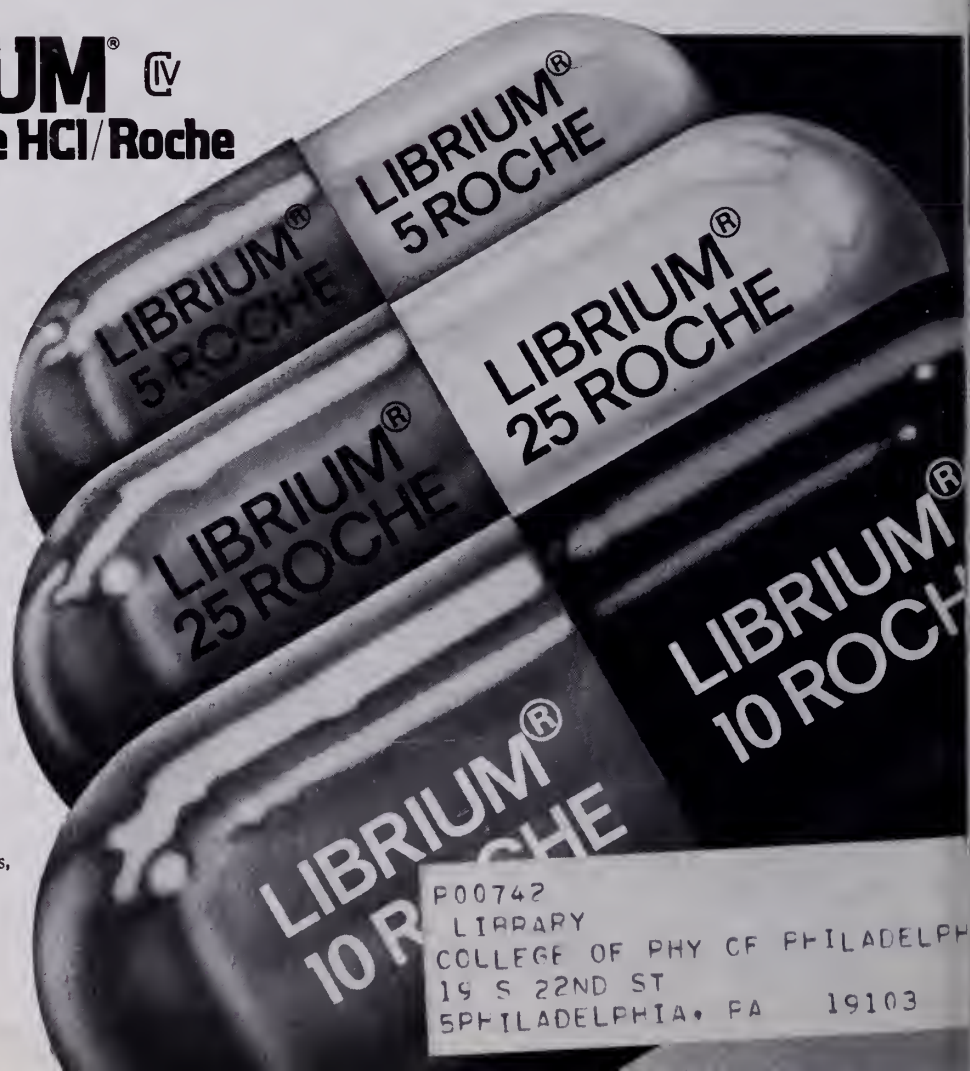
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But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

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tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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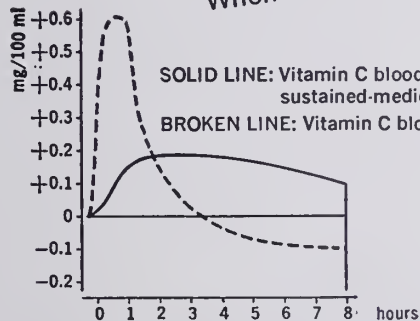


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 *Adaptation

¹ Riccitelli, M. L.: Vitamin C Therapy in Geriatric Practice, J. Amer. Geriatrics Soc. 20: 34, 1972.

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MARCH COVER — The March cover highlights the central theme of this issue—screening children for scoliosis in the schools. It was drawn specially for The Journal by Dr. Robert G. Iglesias, an otolaryngologist in Tampa.



President's Page

The Code Words

"The rising cost of medical care" have become the code words for the attack upon the present system of health care in this country today, and understandably so since cost is the most vulnerable aspect of health care in this country. Quality and availability are lesser problems, and are being improved upon continually. Since the doctor is the key in providing access to the system, the reasoning goes, the blame rests with him, and it is his responsibility to solve the problem. I am not as surprised by this reasoning as I am by the number of our colleagues who accept it as being so.

It is true that the patient gains access to many aspects of the health care delivery system through the physician, and the physician is given a carte blanche use of the patient's wallet in his use of the system. Thus, it is incumbent upon the physician to use this charge account judiciously. Strides are being made along these lines with success in reducing hospital stays, and achieving more stringent use of the laboratory, x-ray, and other ancillary services.

Increasing costs are a result of increasing quality of care, increasing availability of care, and increasing demand for both, and the increasing means to provide them — all this in an inflationary economy.

To maintain a proper perspective, according to the United States Bureau of Labor Statistics, family income rose 43.6% between 1970 and 1975. The cost of medical care for that family in the same period rose 45.7%, hardly a runaway disparity. Thus, the worker works approximately the same hours for increasingly better health care.

The unions, by threat of strike, extort more and more first dollar health care coverage from industry. Then both the unions and management proudly display and take credit for the health insurance package. The workers, thus realizing it is paid for by their labors, feel entitled to use it abundantly, and the upward spiral is continued.

The politicians promise more and more health care, and thus, increasing billions of tax dollars are poured into this system at every port subsidizing research, education, technology, construction, and more and more patient care. Also, the politician demands the welfare patient on Medicaid share the same carpeted, color-televisioned semi-private room as the paying patient, who incidentally is not only paying for his own care, but for that of his Medicaid roommate as well.

So lay the proper share of the blame, and therefore the proper share of the responsibility for solving the problem, at the feet of the physician, and also at the feet of the unions, management, politicians, the Government, the public, and the associated industries involved in the health care field — hospitals, hospital supply companies, equipment manufacturers, pharmaceutical companies, etc. Will the consumer agree to use the system less? Will the manufacturers agree to produce the equipment and supplies at cost, or at a reduced profit? Will the hospital personnel agree to return to substandard wages? Or does the only solution lie in saying to the doctors, "stop raising your fees, and then solve the rest of the problem also." This is not only naive, but misleading. Physicians' fees use 19% of the health care dollar. If fees were slashed 33-1/3% across the board, it would reduce health care costs by one-half of 1% of the gross national product.

The problem is more complex than doctors' fees, and to date no single solution is in sight. It may require a multifaceted, cooperative effort by all concerned. But to suggest that the solution lies with the Government in the form of a national health program which could deliver health care more cheaply is the greatest irony of all.

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Dean's Page

Physician's Assistants — 1977

Chandler A. Stetson, M.D.

Ten years ago there was begun an annual Duke Conference on Physician's Assistants, in recognition of the existence of a nationwide trend toward increasing training opportunities for these health care extenders. In November of 1970, the third annual conference was held, and Dr. W. C. Bornemeier (then President of the American Medical Association) spoke as follows:

"The relatively simple concept of physician's assistants, we of the American Medical Association believe, will go a long way toward answering one of the main problems faced by this country. The American doctor is almost flat on his back, staggering under an unprecedented patient load. The only quick way we see to get him back on his feet . . . is to give him some extra hands."

The Florida Legislature passed a bill in 1971 defining and regulating the functions of a physician's assistant and of physician's assistant training programs. After appropriate amendment of the Medical Practice Act in 1970, the FMA House of Delegates approved a resolution which defines a physician's assistant as: "A skilled person qualified by academic and practical training to provide patient services under the supervision and direction of a licensed physician who is responsible for the performance of that assistant."

The Physician's Assistant program in Gainesville, a program jointly operated by the University of Florida College of Medicine/Santa Fe Community College, has been granted full approval by the State Board of Medical Examiners and by the AMA Council on Medical Education. In its survey of 1975, the Florida Bureau of Comprehensive Health Planning found that 2,239 licensed physicians in Florida indicated that they would have a physician's assistant if one were available. The Gainesville program, currently the only such program in the state, enrolls up to 30 students in each class for a two-year program. Nine months are spent in basic sciences and other didactic classroom work, and the

remainder in six-week clinical rotations under the tutelage of 20 members of the University of Florida College of Medicine faculty. Selection of the most recent class of 30 students was from a pool of 272 applicants, and was based on past academic achievement, previous medical experience, understanding of the need for and role of physician's assistants, and other factors such as desire to enter primary care in an underserved rural area.

To date, 63 highly-motivated and well-trained graduates of this program have been certified, and 51 (81%) are now engaged in primary care in Florida. They are part of the 120 physician's assistants now certified in the state, working in 40 Florida communities; of the 120, over 70% are working in primary care areas.

A recent survey of the results to date in Florida indicates that the employment of physician's assistants does in fact free the physician to spend more time with complicated patients; enables the physician to serve more patients and perform more procedures; decreases patient waiting time and increases overall patient satisfaction with care; increases ability to counsel patients and families and to coordinate patient care with community agencies; and generally has a favorable impact on health care delivery.

Having had a rather skeptical attitude ten years ago with respect to the "physician extender" concept, I must say that my experience with the Gainesville program and its products has thoroughly convinced me that graduates of AMA-approved two-year programs of this sort can play a salutary and very valuable role in physicians' office practices. I venture to say that this approach will turn out to be one of the most cost-effective and satisfactory solutions to the access problem as perceived by the public. We have available a sound-slide educational program on this topic which we will be happy to make available to any interested individual or group on request.

► Dr. Stetson, University of Florida College of Medicine, Gainesville 32610.

Dr. Stetson is Dean and Vice President for Health Affairs, University of Florida College of Medicine, Gainesville.

CIBA nationwide CHEC program reveals*

**An estimated 13 million
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medicine.*¹**



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Once dosage of individual components is titrated to your patient's needs, Ser-Ap-Es can be a logical choice for long-term therapy.

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* CHEC (Community Hypertension Evaluation Clinic), the program that screened 1,049,225 Americans for hypertension, showed that 55.1% of the hypertensives screened were previously undetected, untreated, or uncontrolled. The 13 million figure is a projection based on this percentage and the estimated 24 million hypertensives in the United States. CHEC was a two-year, nationwide study sponsored by CIBA and local health organizations.¹

** Barney Platt is a pseudonym for an actual case history

Please turn page for prescribing information.

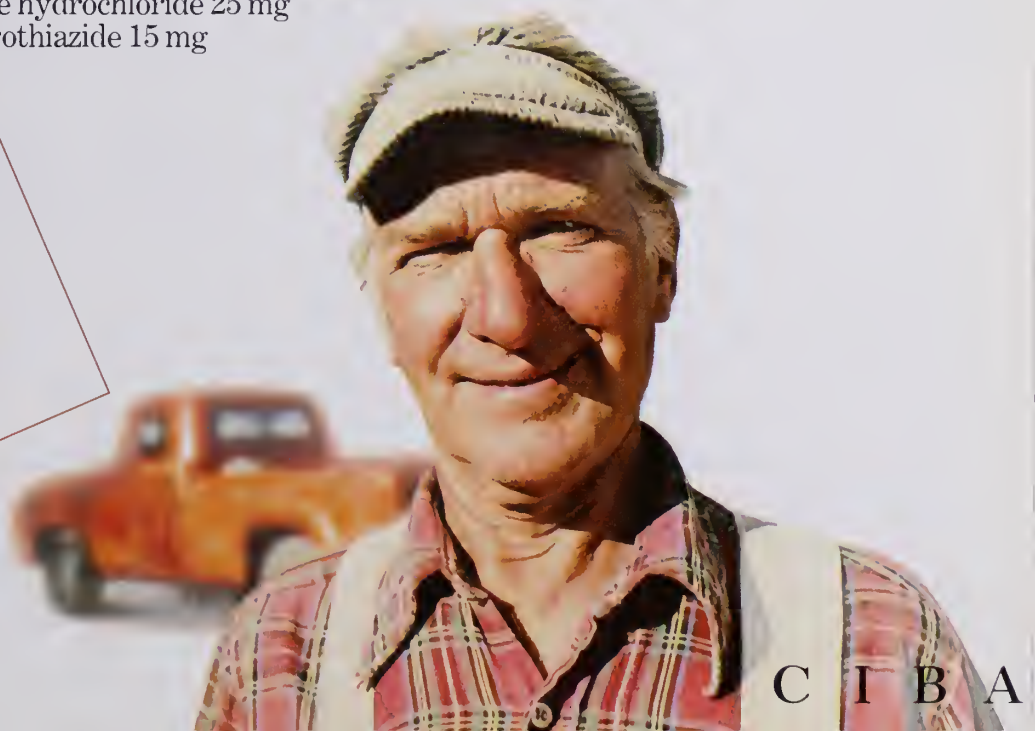


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WARNING

This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

INDICATIONS

Hypertension. (See box warning.)

CONTRAINDICATIONS

Reserpine: Known hypersensitivity; mental depression (especially with suicidal tendencies); active peptic ulcer; ulcerative colitis; electroconvulsive therapy.

Hydralazine: Hypersensitivity; coronary artery disease; mitral valvular rheumatic heart disease.

Hydrochlorothiazide: Anuria; hypersensitivity to this or other sulfonamide-derived drugs.

WARNINGS

Reserpine: Use with extreme caution in patients with a history of mental depression. Discontinue at first sign of despondency, early morning insomnia, loss of appetite, impotence, or self-deprecation. Drug-induced depression may persist for several months after drug withdrawal and may be severe enough to result in suicide.

MAO inhibitors should be avoided or used with extreme caution.

Hydralazine: Hydralazine may produce in a few patients a clinical picture simulating systemic lupus erythematosus. In such patients hydralazine should be discontinued unless the benefit to risk determination requires continued antihypertensive therapy with this drug. Symptoms and signs usually regress when the drug is discontinued but residua have been detected many years later. Long-term treatment with steroids may be necessary.

CBC's, L.E. cell preparations, and antinuclear antibody titer determinations are indicated before and periodically during prolonged therapy with hydralazine or if the patient develops any unexplained signs or symptoms.

A positive antinuclear antibody titer and/or positive L.E. cell reaction requires that the physician carefully weigh the implications of the test results against the benefits to be derived from antihypertensive therapy with hydralazine.

Use MAO inhibitors with caution.

Hydrochlorothiazide: Use with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects of the drug may develop in patients with impaired renal function.

Thiazides should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte imbalance may precipitate hepatic coma. Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs.

Sensitivity reactions are more likely to occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

Usage in Pregnancy

Reserpine: The safety of reserpine for use during pregnancy or lactation has not been established; therefore, the drug should be used in pregnant patients or women of childbearing potential only when, in the judgment of the physician, it is essential to the welfare of the patient. Increased respiratory tract secretions, nasal congestion, cyanosis, and anorexia may occur in neonates and breast-fed infants of reserpine-treated

mothers since reserpine crosses the placental barrier and appears in maternal breast milk.

Hydralazine: Animal studies indicate that high doses of hydralazine are teratogenic in mice, possibly in rabbits, and not in rats. Although clinical experience does not include any positive evidence of adverse effects on the human fetus, hydralazine should be used during pregnancy only if the benefit clearly justifies the potential risk to the fetus.

Hydrochlorothiazide: Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnant women requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

Nursing Mothers: Thiazides appear in breast milk. If the use of the drug is deemed essential, the patient should stop nursing.

PRECAUTIONS

Reserpine: Use cautiously in patients with history of peptic ulcer, ulcerative colitis, or gallstones (biliary colic may be precipitated).

Exercise caution when treating hypertensives with renal insufficiency. Use cautiously with digitalis and quinidine.

Intraoperative hypotension has occurred in hypertensive patients receiving rauwolfia preparations, but withdrawal of reserpine does not assure that circulatory instability will not occur in such patients.

Hydralazine: Use cautiously in suspected coronary artery or other cardiovascular disease, cerebral vascular accidents, and advanced renal damage. Postural hypotension may occur, and the pressor response to epinephrine may be reduced. Peripheral neuritis, evidenced by paresthesias, numbness, and tingling, has been observed. Published evidence suggests an antipyridoxine effect and addition of pyridoxine to the regimen if symptoms develop.

Blood dyscrasias, consisting of reduction in hemoglobin and red cell count, leukopenia, agranulocytosis, and purpura, have been reported. If such abnormalities develop, discontinue therapy. Periodic blood counts are advised during prolonged therapy.

Hydrochlorothiazide: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals. Observe patients for clinical signs of fluid or electrolyte imbalance (hyponatremia, hypochloremic alkalosis, and hypokalemia). Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbance such as nausea or vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of steroids or ACTH.

Interference with adequate oral intake of electrolytes will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effects of digitalis (eg, increased ventricular irritability).

Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver diseases or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Latent diabetes may become manifest during thiazide administration. Thiazide drugs may increase the responsiveness

to tubocurarine. The antihypertensive effects of the drug may be enhanced in the post-sympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathological changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism such as renal lithiasis, bone resorption, and peptic ulceration have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

ADVERSE REACTIONS

Reserpine: *Gastrointestinal*—hypersecretion; nausea; vomiting; anorexia; diarrhea. *Cardiovascular*—angina-like symptoms; arrhythmias (particularly when used concurrently with digitalis or quinidine); bradycardia. *Central Nervous System*—drowsiness; depression; nervousness; paradoxical anxiety; nightmares; rare parkinsonian syndrome and other extrapyramidal tract symptoms; CNS sensitization (manifested by dull sensorium, deafness, glaucoma, uveitis, and optic atrophy). *Miscellaneous*—frequently nasal congestion; pruritus; rash; dryness of mouth; dizziness; headache; dyspnea; syncope; epistaxis; purpura and other hematologic reactions; impotence or decreased libido; dysuria; muscular aches; conjunctival injection; weight gain; breast engorgement; pseudolactation; gynecomastia; rarely water retention with edema in hypertensive patients.

Hydralazine: *Common*—headache; palpitations; anorexia; nausea; vomiting; diarrhea; tachycardia; angina pectoris. *Less frequent*—nasal congestion; flushing; lacrimation; conjunctivitis; peripheral neuritis, evidenced by paresthesias, numbness, and tingling; edema; dizziness; tremors; muscle cramps; psychotic reactions characterized by depression, disorientation, or anxiety; hypersensitivity (including rash, urticaria, pruritus, fever, chills, arthralgia, eosinophilia, and, rarely, hepatitis); constipation; difficulty in micturition; dyspnea; paralytic ileus; lymphadenopathy; splenomegaly; blood dyscrasias, consisting of reduction in hemoglobin and red cell count, leukopenia, agranulocytosis and purpura; hypotension; paradoxical pressor response.

Hydrochlorothiazide: *Gastrointestinal*—anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic), pancreatitis, sialadenitis. *Central Nervous System*—dizziness, vertigo, paresthesias, headache, xanthopsia. *Hematologic*—leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia. *Cardiovascular*—orthostatic hypotension (may be potentiated by alcohol, barbiturates, or narcotics). *Hypersensitivity*—purpura, photosensitivity, rash, urticaria, necrotizing angitis, Stevens-Johnson syndrome, and other hypersensitivity reactions. *Other*—hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness. Whenever adverse reactions are moderate or severe, reduce dosage or withdraw therapy.

DOSAGE

As determined by individual titration (see box warning).

Usual dosage is 1 or 2 tablets t.i.d. For maintenance, adjust dosage to lowest patient requirement. When necessary, more potent antihypertensives may be added gradually in dosages reduced by at least 50 percent.

HOW SUPPLIED

Tablets (light salmon pink, dry-coated), each containing 0.1 mg reserpine, 25 mg hydralazine hydrochloride, and 15 mg hydrochlorothiazide; bottles of 30, 60, 100, 1000 and Accu-Pak® blister units of 100.

Consult complete literature before prescribing.

CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901

Reference

1. Stamler J, Stamler R, Riedlinger WF, et al: Hypertension screening of 1 million Americans. *JAMA* 235:2299-2306, 1976.

C I B A

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***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.
Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.
Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

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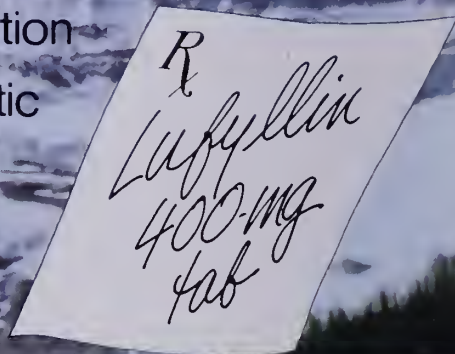
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Following is a Brief Summary:

Indications: For relief of acute bronchial asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema.

Contraindications: In individuals who have shown hypersensitivity to any of its components.

Dyphylline should not be administered concurrently with other xanthine preparations.

Precautions: Use with caution in patients with severe cardiac disease, hypertension, hyperthyroidism, or acute myocardial injury. Particular caution in dose administration must be exercised in patients with peptic ulcers, since the condition may be exacerbated. Chronic oral administration in high doses (500 to 1,000 mg) is usually associated with gastrointestinal irritation.

Great caution should be used in giving dyphylline to patients in congestive heart failure. Such patients have shown markedly prolonged blood level curves which have persisted for long periods following discontinuation of the drug.

Adverse Reactions: Note: Included in this listing which follows are a few adverse reactions which may not have been reported with this specific drug. However, pharmacological similarities among the xanthine drugs require that each of the reactions be considered when dyphylline is administered.

The most consistent adverse reactions are:

1. Gastrointestinal irritation: nausea, vomiting, and epigastric pain, generally precedes the hematemesis, diarrhea.

2. Central nervous system stimulation: irritability, restlessness, insomnia, reflex hyperexcitability, muscle twitching, clonic and tonic generalized convulsions, agitation.

3. Cardiovascular: palpitation, tachycardia, extrasystoles, flushing, marked hypotension, and circulatory failure.

4. Respiratory: tachypnea, respiratory arrest.

5. Renal: albuminuria, increased excretion of renal tubule and red blood cells.

6. Others: fever, dehydration.

Dosage and Administration: Adults—Usual Dose—15 mg/kg every 6 hours, up to four times a day. The dosage should be individualized by titration to the condition and response of the patient, with therapeutic blood levels considered to be between 10 mcg/ml and 20 mcg/ml. Levels above 20 mcg/ml may produce toxic effects.

How Supplied:

LUFYLLIN[®] Tablets—containing 200 mg dyphylline, NDC 0019-R521-92, bottles of 100; NDC 0019-R521-97, bottles of 1000.

LUFYLLIN[®] 400 Tablets—containing 400 mg dyphylline, NDC 0019-R521-98, bottles of 100.

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Actions: Pyrvinium pamoate appears to exert its anthelmintic effect by preventing the parasite from using exogenous carbohydrates. The parasite's endogenous reserves are depleted, and it dies. Povon is not appreciably absorbed from the gastrointestinal tract.

Indication: Povon is indicated for the treatment of enterobiasis.

Warnings: No animal or human reproduction studies have been performed. Therefore, the use of this drug during pregnancy requires that the potential benefits be weighed against its possible hazards to the mother and fetus.

Precautions: To forestall undue concern and help avoid accidental staining, patients and parents should be advised of the staining properties of Povon. Care should be exercised not to spill the suspension because it will stain most materials. Tablets should be swallowed whole to avoid staining of teeth. Parents and patients should be informed that pyrvinium pamoate will color the stool a bright red. This is not harmful to the patient. If emesis occurs, the vomitus will probably be colored red and will stain most materials.

Adverse Reactions:

Nausea, vomiting, cramping, diarrhea, and hypersensitivity reactions (photosensitization and other allergic reactions) have been reported. The gastrointestinal reactions occur more often in older children and adults who have received large doses. Emesis is more frequently seen with Povon Suspension than with Povon Filmseals.

How Supplied: Each Povon Filmseal® contains pyrvinium pamoate equivalent to 50 mg pyrvinium, supplied in bottles of 50 (NDC 0710-0747-50; NSN 6505-00-134-1966). Povon Suspension, a pleasant-tasting, strawberry-flavored preparation containing pyrvinium pamoate equivalent to 10mg pyrvinium per milliliter, is supplied in 2-oz bottles (NDC 0071-1254-31; NSN 6505-00-890-1093).

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RECENT CHANGES

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**Health care doesn't
need more red tape**

**Drug firms challenge
MAC rules**

**Drug
Substitution**

**The Quarterly Communicator
of Health Progress
RESEARCH**

MAA 52 Malgram 2

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



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1155 Fifteenth Street, N.W., Washington, D.C. 20005

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TWO WORDS THAT MIGHT SAVE YOU A 2 A.M. CALL

Mrs. Gomez is frightened.

She has checked into an emergency room because of "a fluttering in her chest." Your examination indicates her palpitations are a drug reaction — prompted by the medication you've prescribed many times before.

The new Florida law requires your pharmacist to substitute a generic drug for your prescription unless you write "medically necessary."

And the substituted prescription could cause an untoward reaction that is both frightening and serious.

The generic may not have the same bioequivalency or bioavailability as the name brand.

The result is, your patient will not get the drug you knew would work. Your carefully considered drug choice is being replaced and, like Mrs. Gomez, your patients and your reputation pay the price.

With the generic, your patient may not get all or may get too much of the medication you prescribe. Or get an impure form of it. Or find it an incompatible vehicle.

The next time you write a prescription, be sure the drug you've ordered is the one your patient gets.

Write "medically necessary" and tell your pharmacist that you want the drug you specify.

Tell your legislator to change the law because it's changing the way you practice medicine, and your patients may suffer in the process.

Put control of medication
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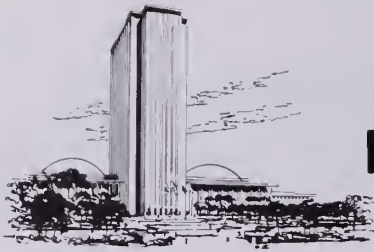
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LEGISLATIVE NEWS

The 1977 Session of the Florida Legislature may place more emphasis on legislative oversight of existing programs than on enactment of new laws. Both Senate President Lew Brantley and House Speaker Don Tucker want to make sure that maximum effectiveness is realized from current state efforts before embarking on new programs that could require new taxes.

While this approach should improve the overall quality of the legislative product, it will not materially effect the ever increasing interest in new health legislation. Already in the "hopper" are concepts to require certificate of need for items of equipment in physicians' offices, limited hospital privileges for chiropractors, expansion of the nurse practice act, and a supermarket selection of various proposals to regulate the health care industry.

Auxiliary Strength Underutilized

The key to success in the legislative process is based upon the strength of relationships developed at the local level. We have received much encouragement and assistance from county medical society legislative chairmen and key contact physicians, and are working hard to improve our flow of information to assist them in this critical task.

It appears, however, that in many areas of the state, the capacity of the FMA auxiliary is not being fully utilized. Under the leadership of Auxiliary Legislative Chairman, Mrs. James White, the members have served notice that they are willing and ready to

work on the 1977 FMA Legislative Program. They have been attending Legislative Committee meetings and participated in several briefings on our program. In addition to the Auxiliary "Day in the Legislature" on April 20 and 21, auxiliary members are assisting with regional workshops to educate physicians and their wives on the political and governmental process.

Be sure your County Medical Societies are urged to take the time now to assure the Auxiliary is being fully utilized. They can assist with letter writing campaigns, distribution of information to physicians on legislative matters, and even serve as legislative contacts! With their help, we can all be more successful.

Drug Substitution—At Issue the Quality of Patient Care

During the summer, the Association has been actively working to insure that the rules implementing Florida's drug substitution law go as far as possible to insure quality drugs being dispensed. FMA has advocated expansion of the negative formulary, consent from the patient when a substitution is made, and other safeguards. These and other changes will likely be made by the Board of Pharmacy during the coming months. Individual physicians can also take action at the local level to insure quality by reviewing the formularies of drug stores used by their patients. Physicians should request a copy of the formulary used by pharmacies in their area. Most pharmacists will welcome this dialogue and it will enable physicians to assist their patient in the selection process.

Submitted by the Council on Legislation and Regulations.

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■ **Relief of Nausea and Vomiting**—Antivert/25 can relieve the nausea and vomiting often associated with vertigo*.

■ **Dosage for Vertigo***—The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

***INDICATIONS.** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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FROM THE EDITOR'S DESK

MEDIATION PANELS

FMA President Jack A. MaCris, M.D., has appealed to FMA members to make themselves available for service on medical mediation panels. The Legislature, in 1975, established the panels to weed out unfounded professional liability lawsuits before they got to trial. Some physicians apparently have refused to serve on the panels, prompting Dr. MaCris' appeal. Conceding that panel service will require a sacrifice of time and effort, our President called on the membership to pitch in to help make the system work. The Florida Supreme Court has upheld the constitutionality of the mediation panels, but the issue is being pursued further through the U.S. Supreme Court.

* * * *

REVERSE LAWSUITS

FMA is keeping close watch on several suits filed in Florida by physicians against former patients and the patients' lawyers. None has come to trial so far, but some have survived motions to dismiss. Generally such lawsuits are based on abuse of process or negligence on the part of attorneys for not properly reviewing his cases.

* * * *

PRACTICE COSTS

The cost of practicing medicine rose faster than increases in fees in the 1960s and 1970s. According to the American Medical Association, overhead costs, including liability insurance, rose by 8.3% a year during 1966 - 74. During the same period, the Consumer Price Index showed fees advancing by 6.2% a year.

* * * *

CME BUDGET

AMA plans to spend \$1.2 million on continuing medical education this year. Up to \$100,000 will be spent on research to determine educational needs

of physicians and to provide guidelines for the structuring of AMA postgraduate programming.

* * * *

HSA BOARDS

Physicians are in the distinct minority on the nation's Health Service Area boards. A tabulation prepared by the Department of HEW shows that of the 5,000 persons appointed to those boards, only 562, or 12%, are M.D.'s.

* * * *

DRUG USE STUDY

The Pharmaceutical Manufacturers Association is underwriting a study of prescription drug usage and adverse reactions. Rising to a challenge by Sen. Edward Kennedy, PMA will spend \$250,000 a year for three years on research. The goal is to design a system for post-marketing surveillance of drugs so that both adverse reactions as well as new drug indications become more quickly known. Both pharmaceutical and medical groups have made nominations for the 18-member Joint Commission on Prescription Drug use.

* * * *

COST OF CARE

Americans spent a whopping \$139.3 billion on health care in fiscal 1976, an increase of 14% over the previous year's spending. The Social Security Administration statistics include personal care as well as public health programs, research, and facilities construction.

* * * *

MEDICAL RECORDS

A congressional subcommittee may conduct hearings this year on the problems of keeping medical records confidential in this age of

computers and vast federal medical programs. Already Chairman John Moss of the House Subcommittee on Oversight and Investigations has expressed concern about the privacy of medical records in the Medicare program. The problem was underscored when a Colorado firm was indicted by a state grand jury there on charges of selling confidential records to large insurance companies.

* * * *

SCREENING PROGRAM

The Medical Screening Program for children (EPSDT - Early Periodic Screening Diagnosis and Treatment) of poor parents has come under attack again. The Southern Regional Council looked at 23 southern communities and found "evidence of bureaucratic and political resistance" to meeting the health needs of Medicaid eligibles under 21 years of age.

* * * *

SPORTS INJURIES

AMA's Committee on the Medical Aspects of Sports is out with the third edition of "Standard Nomenclature of Athletic Injuries." Tailored for physicians who treat athletes, the book contains definitions of terms commonly used in sports medicine. The book is available at \$2.00 per copy from the AMA Order Department.

* * * *

IDAHO COURT RULING

The Idaho Supreme Court has reversed a lower court decision that the state's malpractice law is unconstitutional. The case was remanded for a hearing to the lower court, which had held that the law's \$150,000 cap on awards violated the Idaho Constitution.

* * * *

NEW AMA SECTION

The AMA House of Delegates has established a Section on Medical Schools. The Section will consist of the dean of each approved medical school and three members of each administration or faculty who are to be appointed by the deans.

* * * *

RESIDENT PHYSICIANS

Meanwhile, three more state medical associations —Washington, Illinois and Texas— have established resident physician sections. Six other state societies have formal resident physician sections and about 20 more have some type of arrangement for residents.

* * * *

GALLUP POLL

A Gallup Poll shows that physicians come out on top with the public when it comes to honesty and ethical standards. A nationally representative sample ranked engineers second and college professors third.

* * * *

HEALTH DATA CORPORATION

The newly organized Florida Health Data Corporation plans to file for a corporation charter. James L. Borland Jr., M.D., of Jacksonville, Chairman of the FMA Council on Medical Systems, recently was elected President. Lee R. Ledbetter, Executive Director of the Greater Orange Park Community Hospital, was elected Vice President. Other officers include John C. Hackenberg, D.O., of Jacksonville, Secretary; and Richard Fulford, Assistant Director of Baptist Hospital in Pensacola, Treasurer. The organization is composed of representatives of the FMA, the Florida Osteopathic Medical Association and the Florida Hospital Association.

* * *

MORRIS FISHBEIN FELLOWSHIP

The AMA Board of Trustees has established the Morris Fishbein Fellowship in Medical Journalism. The first Fellow will begin on July 1, 1977 working with senior editors of the **Journal of the American Medical Association** and others engaged in AMA publishing activities. The grant is named in memory of the longtime Editor of JAMA who died last September.

* * *

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Screening for Scoliosis in Florida Schools

Joseph C. Flynn, M.D., Max F. Riddick, M.D., and Thelma L. Keller, R.P.T.

Abstract: Early detection of idiopathic scoliosis in school children can prevent serious deformity. It allows early treatment by simple conservative means and, in most cases, eliminates the need for major surgery for this deformity. In states where a scoliosis detection program has been in effect for several years, serious deformity due to idiopathic scoliosis has virtually disappeared among school children. Such a program is needed in Florida. A pilot scoliosis school screening program in central Florida, sponsored by the Citrus Orthopaedic Society, has screened approximately 40,000 children in grades seven to nine over two years. The program has proved quite successful and is offered as a model for statewide scoliosis screening. The Easter Seal Society and Children's Medical Service of Florida plan to cooperate in a scoliosis screening program throughout Florida in 1977. This program needs the help and support of all FMA physicians. It will bring us a step closer to the annual statewide and state sponsored scoliosis screening program which Florida needs.

Idiopathic scoliosis in adolescents is an insidious, usually symptom-free condition once reported to affect about four out of 1,000 girls and one out of 3,000 boys.¹ The actual incidence appears to be significantly higher. Recent school screening programs for scoliosis in California, Delaware and Minnesota show an incidence of 7% to 11%, including 2% to 3% of curves that need treatment (surgery or brace). The sex ratio is approximately three girls to two boys.²

In idiopathic scoliosis, the curvature tends to become progressively worse until skeletal growth is completed and the epiphyses of the vertebrae spontaneously fuse. Untreated cases may develop visible chest and back deformity and shortness of stature. The late complications are back pain and easy fatigueability. In severe cases, cardiopulmonary embarrassment may shorten life.

Early detection of scoliosis is the key to prevention of severe deformity. If curves are

detected early when they are mild and flexible, a brace or plastic jacket and an exercise program can usually prevent significant deformity. If progressively deforming scoliosis is not detected early, the only effective treatment may be surgery.

Surgery for scoliosis is a formidable undertaking. The child must undergo spinal fusion over one half to two thirds of the spine and must spend most of a year in a cast. The social and psychological effects on the child are significant. The cost of surgical treatment is approximately \$12,000, or about ten times the cost of nonoperative treatment.

The most effective means of early detection of scoliosis is through screening of school children. In Delaware,³ where school screening has been in progress over ten years, serious deformity due to idiopathic scoliosis has virtually disappeared among public school children. Minnesota and Wisconsin also have state screening programs.⁴ Other states such as Massachusetts and California have regional programs.

In Florida, a pilot program of scoliosis screening has been in progress in Orange and Lake Counties for two years.⁵ Patterned on this pilot program, countywide screening is now being done in Brevard, Seminole and Monroe Counties. Limited screening has been initiated in Duval, Dade and Volusia Counties. Palm Beach, Lee, Marion, Osceola and Leon Counties are planning screening. It is our hope that statewide comprehensive screening will grow from this small start. The following is a brief resume of our experience with the initial pilot project.

The Orange County Pilot Program

The Orange County program is sponsored by the Citrus Orthopaedic Society. The program is approved by the Orange County Medical Society and enthusiastically received and carried out by Orange County school personnel. In 1975 all Orange County Junior High School physical education teachers attended a scoliosis orientation

and screening training session. Later, these trained physical education teachers examined all children in grades seven, eight and nine. Grades seven to nine were designated for the pilot study for three practical reasons: First, Orange County has only 19 junior high schools while it has 71 elementary schools. Second, it is quite easy for physical education teachers to screen children during gym class. Third, these youngsters are a large part of the rapidly growing vulnerable ten to 15-year-old age group.

These teachers identify those children who have some physical findings suggestive of scoliosis. At a mutually convenient time, a volunteer member of the Citrus Orthopaedic Society examines these children at the school. Those with findings suggestive of scoliosis are referred to their private physician or the Orange County Health Department. The Health Department refers indigent children to the Children's Medical Services or the Elk's Harry Anna Crippled Children's Hospital Scoliosis Clinic at Eustis, Florida, where free x-ray and consultation are available.

Results

Table I shows results of two years of screening. Nearly 40,000 children were examined. About 10% were identified by physical education teachers as having a possible spinal deformity. Slightly less than 2% of the total number of children were referred to their private physicians or the Health Department with recommendation for x-ray evaluation of the spine. Statistics beyond this point are incomplete. For 1975, 34 of the 473 children referred are known to be under treatment with exercises, brace or surgery.

Under the present system we have incomplete continuity of follow-up. Children in 1975 took home a letter to the parents explaining the nature of scoliosis and recommending examination by the family doctor or orthopedist of their choice. We believe some of these letters never reached home, some were ignored and perhaps some were not

pursued because the family could not afford private care. In 1976 a new letter sent home with the children gave instructions to contact the County Health Department if financial help was needed. Also, a postcard was sent to be checked by the parent and returned to screening headquarters, designating the type of facility to which the child would be taken.

A State-Wide Screening Program

We need, in Florida, a state-sponsored and supported program with follow-up by State Health Department nurses and school nurses as is done in Wisconsin and Minnesota. Such follow-up would insure that the designated children are taken to a scoliosis evaluation treatment facility. Our Orange County plan is workable in this area of central Florida because an adequate number of willing volunteer physicians are available to do the secondary screening. For statewide screening, a more practical plan is a state-supported plan in which public health and school nurses as well as volunteer physical therapists and occupational therapists do the secondary screening. The physician enters the process at the final or diagnostic level. At this diagnostic level, we need free scoliotic screening x-ray provided at strategic points in the state, much the same as chest x-ray facilities for tuberculosis detection. This plan would enable the screening program to reach all corners of the state. It would provide the authority, mechanism of follow-up, and assure continuity of the program.

Progress Toward Future State Support

The School Health Advisory Committee of the Florida Medical Association, headed by Dr. Marvin S. Allen, and including Dr. Emily Gates, Administrative Chief of Child Health Care for the State Division of Health, has reviewed our experience with the pilot program. The committee recommended statewide screening, using state personnel.

Florida Statute 402.32, known as the School Health Services Act of 1974, already authorizes screening for scoliosis and other conditions in the Florida schools. However, funding for such a program by the legislature is lacking. The Florida Orthopedic Society strongly supports a statewide scoliosis screening program. The support of individual county medical societies and of the Florida Medical Association is necessary to influence the legislature to fund a state program. With the support of the FMA, annual statewide scoliosis screening of schools can become a reality.

Table I — Scoliosis Screening, Orange County Schools, Grades 7-9, 1975-1976.

	TOTAL	BOYS	GIRLS
No. of Schools Screened	19		
No. Students Screened	38,710	20,043	18,667
Rescreened by M.D.	4,105	2,016	2,089
Referred to M.D. or Agency	711	297	414
Percent of Total	1.8	0.77	1.07

Status of State Screening for 1977

Meanwhile, we are moving closer to a statewide program as a result of support by the Easter Seal Society and Children's Medical Service of Florida. These organizations plan to cooperate in a scoliosis screening program throughout Florida beginning in 1977.

The local program, established by Easter Seal with the cooperation of Children's Medical Services and the Florida State Elks, will be a large second step in the establishment of an annual Florida state-sponsored and supported scoliosis school screening program. Such local programs will make it simpler for other Florida agencies to cooperate by providing help from their personnel in screening and follow-up.

Volunteer physicians, nurses, physical therapists and occupational therapists interested in helping in their area should contact their local Easter Seal Society.

Physical education teachers, anxious to help initiate screening in their area, should contact their County School Superintendent, who in turn, should contact the local Easter Seal Society or the Citrus Orthopaedic society.

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3. Hensinger, R. N.; Cowell, H. E.; MacEwen, G. D., and Shands, A. R. Jr.: Orthopaedic Screening of School Age Children, Review of a 10 Year Experience, Ortho. Rev. IV:23-28 (Jan.) 1975.
4. Thompson, B.: Slow Dangerous Curve, Wisconsin Dept. Public Instruction, Booklet, 1974.
5. Winter, R. B.: Early Detection of Scoliosis by School Screening. Booklet. Twin Cities Scoliosis Center, Minnesota Dept. Health and Minnesota Dept. Education, (July) 1975.
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- Dr. Flynn, 1315 South Orange Avenue, Orlando, 32806.

Booklets containing detailed instructions for setting up a county screening program may be obtained for \$1.50 from Scoliosis Screening Coordinator, Citrus Orthopaedic Society, P. O. Box 6991, Orlando, Florida 32803.

Editorial Comment by Louis B. St. Petery Jr., M.D.

At its Board of Directors meeting on July 24, 1976, the Easter Seal Society of Florida endorsed scoliosis screening in schools as the society's primary annual project. This action was enhanced by the recommendations of Dr. William J. Hutchison, Tallahassee orthopedic surgeon, serving as Chairman of the society's Professional Advisory Committee. Subsequently, the Florida delegation to the National Society proposed and saw adopted scoliosis screening as a nationwide Easter Seal project.

The Children's Medical Services Program, which is the Crippled Children's agency in the Florida Department of Health and Rehabilitative Services, shares particular interest in scoliosis screening as a preventive and beneficial measure, since Children's Medical Services has spent over \$95,000 in the past three years for the surgical procedures **alone** to correct scoliosis in children.

Following the leadership of such dedicated persons as Dr. Flynn and company, whose experience in Orange and Lake counties is documented in his article, several other counties have undertaken screening. The major constraint identified in the Leon County scoliosis screening effort of January, 1977, related the School Health

Act's requirement that parents or guardians provide their written permission for screening. To make certain that this statutory requirement is met, and that the maximum number of children have written permission, consent forms must be worded to encourage parental understanding of the importance of screening. Sufficient turn-around time must be planned for consent forms to be returned prior to screening dates.

Successful implementation of screening requires pre-planning to assure the necessary understanding and participation by the private sector (i.e., local medical societies), the voluntary health agencies (i.e., Easter Seal, Elks), and the public sector (i.e., local school authorities, the Health Program, the Children's Medical Services Program).

Despite current lack of funding for the School Health Act of 1974, Florida school children at risk for idiopathic scoliosis may benefit greatly by a coalescence of community resources. Please consider supporting participating in, and/or initiating screening for scoliosis in your community.

- Dr. St. Petery, 3975 W. W. Kelly Road, Tallahassee 32301.

The Child With Scoliosis A Parent's Viewpoint

Ruth and Dick Conti

In November, 1975, we inadvertently discovered curvature in the spine in our 13 year-old girl. This was noted while she was practicing cheerleading and was bending over with one of the other children standing on her back. They noticed that there was an unevenness to her back and called this to our attention. It was very clear to both of us that our daughter had a rather severe spinal deformity that we had not noticed before. Obviously, as parents, we were greatly concerned.

Jennifer was evaluated by an orthopedic surgeon, who, after examination and x-rays, found our daughter to have a 40-degree curvature of her spine. This is considered severe at age 13, and it represents a degree of curvature where one begins to consider surgery. You can imagine how we felt when we were told that our previously healthy, normally active child might have to undergo a major surgical procedure. The alternative to surgery was an upper body cast for one month, followed by an upper body brace for a four year period of time. When we learned of these alternatives, we are certain that we were more depressed than our daughter. Many things ran through our mind at that time, including how this was going to affect Jennifer's teenage life; her relationships with her friends; her ability to participate in dancing and skiing; and most important to our daughter, how was this going to affect her chances of making the cheerleading squad. It was a pathetic sight to see a healthy young girl being put into an upper body cast. Both of us were very concerned about our child's emotional state. However, an amazing thing happened! Jennifer took to the cast like a turtle. Within 24-hours the cast was multi-colored and signed by all of her friends. I am sure that many of her friends were sympathetic about the problem, but she was clearly accepted by her classmates. In no time at all, she was doing everything that she had been doing previously. After one month in the cast, she was put in a brace that she had to wear 23 hours

a day. Furthermore, she was told that she would have to wear it for the next four years. In addition to the brace, she was required to do many back exercises both in and out of the brace.

Although we were less depressed about the appearance of the brace and its activity restrictions, we still had some concerns relating to its effect on the life of a teenage girl. Jennifer quickly solved that problem by making it clear to us that she was going to do everything that anybody else could do. She quickly realized that the only limitations of the brace were that she could not lift her head while bending over, and that she could not play tennis well since she could not turn her body at a right angle to her head. At any rate, she made the cheerleading squad against some rather stiff competition even though she was in the brace!

Both of us have learned a great deal about our daughter's ability to adapt to a potentially very stressful situation. We are certain that this circumstance had an emotional effect on our child; but we are both convinced that it affected us more than Jennifer. Despite our initial depression, we are now convinced that Jennifer is a stable individual. She, with proper support and motivation from her physician and her parents, along with her own very strong motivation to succeed, will weather this storm in her life, both from the emotional and physical point of view. We think that all parents of children with this condition should be encouraged by the response of our child and many others like her. Children have remarkable powers of adaptation to stressful situations that maybe we, as adults, should try to copy.

We hope that other parents of children with this deformity will benefit from some of our experiences.

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Propoxyphene-Induced Hypoglycemia

Luis R. Florez, M.D., John Rozanski, M.D., Albert Castro, Ph.D.,
and Daniel H. Mintz, M.D.

Abstract: Recurring episodes of hypoglycemia occurred in a 54-year-old man with diabetes and a six-year history of chronic renal insufficiency following administration of propoxyphene (Darvon). The analgesic induced hypoglycemia not only in the patient but in a normal volunteer subject after a 15-hour and 62-hour fast respectively. Because of widespread use of propoxyphene, this potential adverse reaction appears worthy of note. The mechanism of the hypoglycemia warrants further study.

The pharmacologic actions of the sulfonylureas and biguanide classes of hypoglycemia-inducing drugs are well known. Other pharmacologic agents have been implicated as rare causal agents of severe hypoglycemia including the salicylates, sulfonamides, chlorpromazine, propranolol, haloperidol, para-aminobenzoic acid, and alcohol.¹⁻⁶ They are believed to interfere with gluconeogenesis or potentiation of oral hypoglycemic agents.

In 1967 Wiederholt, Genco and Foley reported the first case of propoxyphene-induced (Darvon) hypoglycemia.¹ No other cases, to our knowledge, have been reported. Frizzell, Larsen and Field described two patients with chronic renal failure and unexplained spontaneous hypoglycemia, one of whom had taken propoxyphene.⁷ The medication, together with its various compounded preparations, is one of the most widely prescribed analgesics.⁸

This case involving renal failure and propoxyphene-induced hypoglycemia is believed to be the second reported case, and the first in a diabetic patient.

Case Report

A 54-year-old man with diabetes mellitus and severe renal insufficiency was admitted to the Clinical Research Unit of the University of Miami Hospital and Clinics because of recurrent episodes of hypoglycemia symptoms which had begun suddenly two months previously.

The medical history included: Diabetes mellitus, diagnosed in 1963, was treated with 20 units of NPH insulin daily. Renal insufficiency related to diabetes occurred in 1967 and a hemodialysis program had been initiated two

months prior to admission. Propoxyphene 65 mg orally was given every four hours as needed for pain over the shunt site and for headaches. After several days the patient experienced the first of several hypoglycemic episodes with glucose levels as low as 45 mg%. Insulin therapy was withdrawn but episodes of hypoglycemia persisted. Serial blood glucose levels were not determined.

Examination revealed the patient to be well developed, well nourished and in no acute distress, temperature 37°C, pulse 64, blood pressure 160/90 mm Hg, respiration 16 per minute, and weight 165 pounds. There was trace ankle edema, greatly decreased pulses below the femoral arteries and ulceration at the medical aspect of the first toe of the right foot. A reducible right inguinal hernia was noted.

Laboratory examination showed hemoglobin 12 gm% and hematocrit 39%. The white blood cell count was 6,300 with normal differential. Other laboratory data included sodium 138 mEq/L, potassium 5.5 mEq/L, chloride 94 mEq/L, carbon dioxide 25 mEq/L, BUN 103 mg%, glucose 120 mg%, total protein 8.5 gm, albumin 4.1 gm, creatinine 10.5 mg%, calcium 9.3 mg%, phosphate 7.9 mg%, uric acid 8.6 mg%, and total cholesterol 172 mg%. Urinalysis demonstrated 4+ proteinuria with a specific gravity of 1.017 and trace glucose. Chest x-ray revealed cardiomegaly. The electrocardiographic pattern was consistent with left ventricular hypertrophy. Upper GI, small bowel series and barium enema were normal.

Special Studies

After 62 hours fasting without propoxyphene, the patient did not exhibit hypoglycemic symptoms and the plasma glucose level was 70 mg%. (In our laboratory normal range is 70-100 mg%.) Another fast was attempted while the patient received 130 mg of propoxyphene orally every four hours. (The dosage was doubled due to continued pain.) After 15 hours he complained of weakness, lightheadedness, and diaphoresis, and the fast was terminated. The plasma glucose level at that time was 50 mg%. A four-hour oral glucose tolerance test and tolbutamide test were carried out before and after propoxyphene (Figs. 1 & 2). Glucose levels were consistently lower after propoxyphene.

A normal volunteer subject was studied during a 72-hour fast before and after administration of propoxyphene. Hypoglycemia was not experienced without propoxyphene, but with drug administration symptomatic hypoglycemia emerged after 62 hours. Blood sugar and plasma immunoreactive insulin levels determined at that time were 50 mg% and 7 μ U per ml. Plasma immunoreactive insulin responses were assessed during an oral glucose tolerance test⁹ and following 1 mg glucagon. The glucagon was administered intravenously before and after propoxyphene, 130 mg every four hours for 24 hours. Blood glucose and plasma insulin responses to the oral glucose and intravenous glucagon were not significantly altered by the drug.

Discussion

Propoxyphene hydrochloride is a mild analgesic, structurally related to the narcotic analgesic, methadone. Adverse reactions most commonly include rash, headache, sedation, dermatitis, dizziness,

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nausea, and vomiting.¹⁰ Chronic ingestion of large doses or toxic overdosage has resulted in psychosis, convulsions, and death.^{8,10-12} Many of these symptoms and signs are analogous to those observed in hypoglycemia (nausea, vomiting, alterations in mental status, coma, generalized or localized seizures) but invariably blood glucose levels have not been reported.

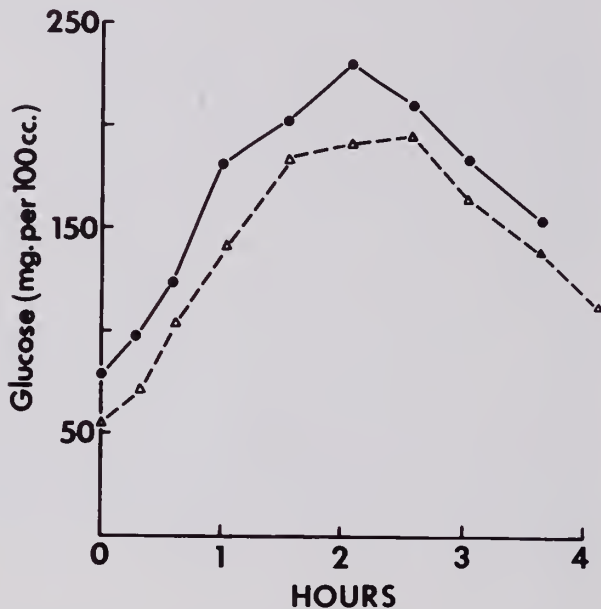


Fig. 1.—Four-hour oral glucose tolerance test. Circles represent plasma glucose before propoxyphene, triangles after the drug.

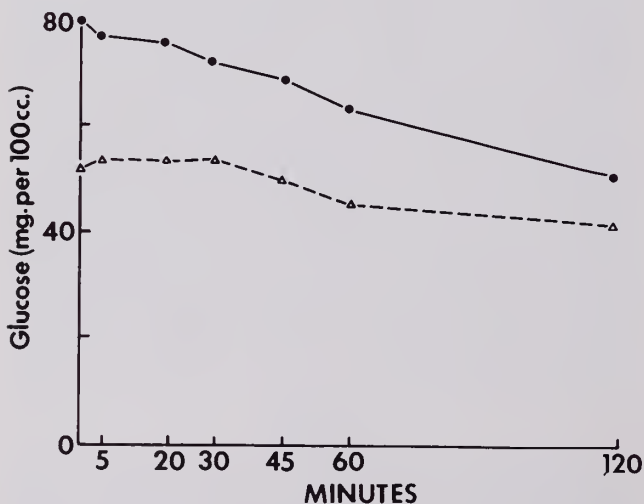


Fig. 2.—Tolbutamide tolerance test. Circles represent plasma glucose before propoxyphene, triangles after the drug.

In our case glucose levels in the fasting state, oral glucose tolerance test, and tolbutamide test were consistently lower after propoxyphene had been given in commonly used doses. Hypoglycemia in both the patient and a volunteer appeared only when fasting and drug administration were combined, suggesting that propoxyphene may interfere with gluconeogenesis. Preliminary information in studies of other normal individuals suggests that propoxyphene does not interfere with the insulin release mechanisms.

The role of renal failure cannot be fully assessed at this time. Theoretically, renal failure should not change the fate of propoxyphene since it is predominantly metabolized in the liver, largely by N-demethylation, and only 10% of an administered dose can be recovered in the urine.¹³ In published data, however, and in our patient renal insufficiency was present. Utmost care should be taken in administration of propoxyphene, especially in patients with chronic renal failure.

Acknowledgments

We express our appreciation to Drs. Joel Mann and Peter Weissman for referral of the patient and continued support.

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Long-Term Therapy for the Mental Disturbances of Wernicke-Korsakoff Syndrome

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Abstract: The mental disturbances of Wernicke-Korsakoff syndrome have been reported in some texts to be irreversible. Three cases are reported in which relatively severe initial disturbances were significantly improved by intensive initial therapy and persistent follow-up care. Brief comments on the signs and symptoms of the Wernicke-Korsakoff syndrome and its pathophysiology are also included.

The mental disturbances associated with Wernicke-Korsakoff syndrome have been said by some authorities to be irreversible if well established¹ and quite slow to respond in even the relatively early cases. In three consecutive relatively advanced cases, disturbed mental function has been the slowest of the signs of the syndrome to respond to specific therapy, but response to a dramatic degree has been achieved in each case with long-term follow-up treatment.

Report of Cases

Case 1. — This 61-year-old female had complained for about one month of numbness of the legs and swelling of the abdomen when first seen as an outpatient. Examination revealed no abnormalities except obesity. No objective loss of peripheral sensation or abdominal distension was demonstrated. One week later the "numbness" had progressed quite rapidly and she began experiencing great difficulty walking. On hospitalization, physical examination revealed horizontal nystagmus, marked weakness of the lower extremities, and decreased position sensation in the toes. Heel-to-shin test was poorly coordinated bilaterally, but other tests of cerebellar function were normal. Initially, the patient stoutly denied more than "social" drinking.

Initial laboratory studies revealed a nonreactive VDRL, normal 3-hour glucose tolerance test, normal lumbar puncture and spinal fluid examination, normal Schilling test, normal T₃ and T₄, negative urine screen for heavy metals, negative skull x-ray and brain scan, and no significant abnormalities of the thoracic or lumbar spine on x-ray. Following neurosurgical consultation, a total myelogram was obtained and also was found to be negative.

Steadily the patient's lower extremity weakness increased until she was unable to lift either leg from the bed. Concurrently,

mental function rapidly deteriorated, primarily in terms of loss of short-term memory. This pattern progressed to the extent that the patient would greet her physician as though he had just arrived and then would rediscover her loss of lower extremity function every few minutes during the course of prolonged bedside visits. As she rapidly deteriorated her family finally admitted that she had for many years had a heavy, daily alcoholic intake and that in recent months her intake of other nutrients had become quite erratic. Initially, specific therapy was begun with 50 mg thiamine each day. After two weeks, there had been only minimal improvement. Thiamine dosage was then increased to 400 mg per day for a period of five days. During this period there was marked improvement in leg strength. She was then once more placed on a maintenance dose of 50 mg each day. After an additional week of hospitalization, transfer was made to a long-term care facility. Over the following two months she steadily improved in strength with the eventual return of normal ambulation and no complaints referable to her extremities. Over the next three to four months signs of improvement in short-term memory began to appear. By 12 months after initiation of therapy, mental function had improved to the point that she was able to return home. In the 16 months since then, she has remained abstinent from alcohol, taken thiamine, 50 mg each day, and functioned quite well with only minimal short-term memory difficulties such as occasionally forgetting where she placed things, etc.

Case 2. — This 84-year-old male was referred for hospitalization by a physician from a neighboring community with no initial history available other than that of confusion and headaches for two to three days and the finding of hypertension just prior to referral. Subsequently it was learned that he had a long history of heavy alcohol intake and that he also complained of chest and arm pain for one to two days prior to admission.

Initial examination revealed total disorientation to time or place. The liver was palpable four finger breadths below the right costal margin. Blood pressure was 180/110, pulse was 100, and the patient demonstrated agitation felt to be suggestive of delirium tremens. Initial studies revealed acute anteroseptal myocardial infarction. Treatment was begun with the usual measures for acute myocardial injury and this subsequently stabilized and cleared with no significant cardiac complications. In addition, he was begun on a regimen of vitamin replacement, fluids, electrolyte control, and psychotropic medication to control the acute psychosis. After approximately 12 hours, his mental status changed to one of marked somnolence, which persisted for the following five days despite discontinuation of all sedatives. He then once more began to grow alert but was noted to remain disoriented to time and place. Attempts to begin increasing activity as he recovered from the myocardial infarction were hampered by inability to walk due to "numbness" in both legs. He was noted to confabulate a great deal when questioned. The minimal dosage of thiamine which he had previously received was therefore changed to 100 mg per day. For the next 12 days his status remained essentially unchanged.

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His mental status then deteriorated once more to a level of marked somnolence. This progressed with occasional periods of improvement for six days when the patient suddenly became apneic and cyanotic during a meal. Subsequent studies revealed aspiration pneumonitis and for a period of four days he required respiratory assistance as well as parenteral corticosteroid and antibiotic therapy. When this episode had been controlled and the respirator discontinued, he was continued on 50 mg of thiamine twice each day. His course thereafter was one of slow but steady improvement. Orientation to time and place were reestablished, confabulation ceased, and mental function returned to his prior level of apparently above average intelligence. Function of the lower extremities improved more slowly, but by the time of discharge (50 days after admission) he was able to get about with the assistance of a walker. Following discharge, he continued thiamine, 100 mg each day for one month. During this time his leg strength had increased progressively and his mental function remained normal. Thiamine was then decreased to 50 mg each day and has been maintained at that level for 18 months since. He now walks 18 holes of golf several times each week, is mentally bright, and has no apparent residua of this disease. He has remained abstinent from alcohol.

Case 3 — This 67-year-old male had a long history of chronic alcoholism and had been hospitalized two months previously by his family physician for evaluation of increasing disorientation and agitation. During that admission, brain scan and skull x-rays were negative, while electroencephalogram was said to show irregular abnormal activity. Initially he was transferred to a long-term care facility on a therapeutic regimen consisting primarily of tranquilizers and medication for longstanding chronic bronchitis and obstructive lung disease. Subsequently he had been taken home, but rehospitalization became necessary when signs and symptoms developed of acute bronchitis, decreased pulmonary function, and further deterioration of mental function.

Examination on admission revealed marked emaciation. The patient was disoriented to time and place and attempted rather ineffectively to confabulate when pressed for specific history. Rales, rhonchi, and expiratory wheezing were scattered throughout both lung fields.

Initial studies revealed rather marked respiratory acidosis with no acute changes noted on chest x-ray. With appropriate therapy, the patient's dyspnea, increased sputum production, and acid-base imbalance improved during the first week of hospitalization, but his mental status remained unchanged. Repeat electroencephalogram showed severe, diffuse abnormalities with marked deterioration since the previous tracing. Right carotid arteriography revealed no evidence of mass lesion or midline shift and was felt to be a negative study. Because of the prior history of alcoholism and of longstanding dementia, thiamine was begun at 200 mg per day and subsequently increased to 400 mg per day. During the remainder of hospitalization, adjustments were made in dosage of psychotropic medications in an attempt to control mental abnormalities. Generally he continued to vary from periods of partial orientation lasting up to two to three days to periods of marked disorientation and confabulation, with periods of marked somnolence sometimes lasting for several days. After 45 days of hospitalization, he was finally transferred back to an extended care facility on a reduced dose of thiamine at 50 mg per day and again was soon taken home. Initially his sensorium remained little changed, but gradually improvement began to be evident. By two months following initiation of thiamine therapy he had again become oriented to time and place and had improved to the

point that he was able to become interested once more in visiting friends and conversing rationally. Shortly thereafter he suddenly died one night in his sleep.

Comment

Wernicke's disease is characterized by mental disturbances, ataxia, altered ocular motility including lateral rectus weakness and/or horizontal nystagmus, and sometimes polyneuropathy. Korsakoff's psychosis is the particular form of mental disturbance frequently seen in such cases in which there is a loss of short-term memory and a tendency to confabulation. The three patients reported here were all believed to have the Wernicke-Korsakoff syndrome to a significant degree. Two cases were complicated by other conditions, including delirium tremens, acute myocardial infarction, aspiration pneumonia (case 2) and chronic obstructive lung disease (case 3).

The Wernicke-Korsakoff syndrome has long been known to be a disease of nutrition and was shown in 1952 by Phillips et al to be due specifically to thiamine deficiency.² These workers showed that ophthalmoplegia often clears within hours of initiation of thiamine, nystagmus may clear within days, and ataxia may take weeks to months to clear. They commented that mental disturbances are apparently much slower to clear, though their study was not adequately prolonged to demonstrate such clearing. Although chronic alcoholism is the most common cause of this disease, it has been pointed out by several authors that the clinical syndrome and the associated pathologic findings have been seen in other conditions, including hyperemesis of pregnancy, carcinoma of the esophagus and stomach, Billroth II gastrojejunostomy, acute pancreatitis, hemodialysis, retroperitoneal carcinoma, oat cell carcinoma of the lung, intracranial lesions, and intravenous hyperalimentation.^{3,4}

The pathogenetic mechanism by which thiamine deficiency appears to produce neurologic disease is in the effect on transketolase levels, an enzyme known to be thiamine dependent. Serum levels of transketolase have been shown to drop in thiamine deficiency and to rise rapidly when thiamine replacement is begun. This enzyme is also dependent on adequate magnesium levels, and it has been found that, in at least one case where there was coexistent magnesium deficiency, neither clinical nor transketolase level recovery occurred until magnesium as well as thiamine had been replaced.⁵

The personality patterns of patients with Wernicke-Korsakoff syndrome have been found to be similar in many ways to those seen in senile dementia, with outstanding characteristics being those of trustfulness, obedience, and timidity.⁶ The nature of the memory defect in Korsakoff's psychosis has been of great interest to several workers. Some have characterized the condition as amnesia due to "proactive inhibition," i.e., the crowding out of new material by memories already present.⁷ Special testing methods have shown an abnormality in the ability of patients with Korsakoff's syndrome to encode new information into their memories on more than a very superficial basis, with failure to attach enough semantic meaning to new information to allow them to retain the memory.^{8,9}

In the three cases reported here, mental disturbances developed to a point of total disability, with marked somnolence and disorientation in two cases and advanced Korsakoff's psychosis in the other. In all three cases, initial high dose thiamine followed by continued maintenance doses and associated with abstinence from alcohol and good supportive care resulted in dramatic improvement in mental function in from six weeks to 12 months time. Two of these patients have subsequently been followed for over a year and have both enjoyed quite meaningful and active lifestyles, which might not have been thought possible during the acute phases of their illness.

Though some patients with Wernicke-Korsakoff disease undoubtedly do sustain damaged mental function to an irreversible extent, it is apparent that this is not necessarily the case even when the initial illness appears to be advanced. In view of the potential for improvement demonstrated by these cases, aggressive initial therapy and persistent long-term care, including maintenance of therapeutic doses of thiamine, is certainly indicated.

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Cracker Cures

Chickenpox:

To make rash break out, take child in the chicken house before daylight and let chickens fly out over his head.

The cure is to make child stay in chicken house all day long and feed him sassafras tea.

Reprinted by permission from "Cracker Cures," a publication by the Peace River Valley Historical Society. Edited by Cedric Stephen Wood, P.E. These cures have been collected over the years by friends and members of the Peace River Valley Historical Society and presented a few at a time at each of their regular meetings by Dr. Gordon H. McSwain, custodian.



Just what is Florida Drug Utilization Review all about?

Drug Utilization Review is part of the Medicaid drug program in your state. The goal is to assist in the delivery of rational drug therapy for Medicaid patients and reduce the over all cost of the Medicaid drug program.

How can Drug Utilization Review do that?

It is done by reviewing Medicaid drug use and sharing the results of the review with those doctors and pharmacists involved in treating the patient. When a Medicaid prescription claim is processed, a computer records who received the drug, who prescribed it, who dispensed it, and what kind of drug it was. Once a month, the computer compares the drug use records of each patient with several criteria, such as kinds of drugs used, amounts purchased, number of doctors visited, and so on.

When a patient's drug use goes beyond any of the criteria, the computer prints a report for review by the Drug Utilization Review Committee.

Just who is the Drug Utilization Review committee?

It is a group of fellow health care professionals—pharmacists and physicians from your area. Committee members are selected from nominations made through local pharmacy and medical groups. Each member serves for 1 to 3 years. You may be invited to serve on the committee at some time.

What does the Drug Utilization Review committee do?

The committee reviews patient drug histories showing drug use patterns which exceed criteria set for the program. If the questionable pattern appears to be minor or temporary, the committee may decide to take no further action.

If the situation is more serious, the committee will write to the pharmacists and physicians involved to advise them of the potential problem. For example, the records might show that a patient is going to several doctors and/or pharmacies to obtain the same drug. The committee would advise each of the professionals involved of this practice. In another case, the committee might recommend that a doctor prescribe maintenance drugs in larger, more economical quantities if the patient's condition warrants it.

Are the committees trying to dictate drug therapy?

Not at all. The committees want to leave drug therapy in the hands of the physicians and pharmacists, where it belongs. All Drug Utilization Review does is give you information about your patients' drug use that hasn't been available before. The committee can't dictate the kind of drug therapy used, and wouldn't want to if it could.

What do I have to do if I get a letter about a patient?

If the situation described in the letter is warranted by the patient's condition, please give the committee any information you might have that shows that the drug use is appropriate.

On the other hand, if the situation is one of inappropriate or inefficient drug use, the committee asks that you do what you can to correct it.

How can a pharmacist find out more about the Drug Utilization Program?

A pamphlet which explains the Drug Utilization Review program in detail is available or a visit to your pharmacy by a staff member can be arranged upon request. A speaker or a color/sound film can also be provided for local pharmaceutical associations or other groups interested in further information about the program. Your peers who are members of local peer review committees will be glad to explain the program personally or answer any questions. If you will write or call PAID Prescriptions, any information requested will be provided including the names of committee members in your local area.



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SPECIAL ARTICLES

Ethics in Everyday Medical Practice

Ronald A. Carson, Ph.D.

Abstract: The physician's role is in flux today. There is no longer a broad consensus regarding the place of medical practice in the society. Doctors are expected, as always, to treat the ills of the body. Does this include or exclude attention to "problems in living"? To whom are physicians, as professionals, accountable? To themselves? To their peers? To their patients? Public discussion of such questions is generating considerable heat and, occasionally, some light as well. Meanwhile, doctors and patients continue to interact. Ethics provides a means of sorting out the changing character of this interaction by developing models for comparison and evaluation.

Interest in the role of human values in medicine is on the rise. The very existence and increasing prominence of such organizations as the Society for Health and Human Values, The Institute of Society, Ethics and the Life Sciences, and the Kennedy Institute's Center for Bioethics attest to this interest. In medical schools as well, the volume of programmatic instruction in the general area of "medicine and society" has grown phenomenally in the last five years. The **Journal of the American Medical Association** reports that 97 of the 107 American medical schools recently surveyed offer some formal medical ethics teaching as a part of their curricula.¹

"Medical ethics" most commonly refers to those problems which are currently very much in the public limelight. The recent discussions of the moral and legal quandaries arising in the Karen Ann Quinlan case are evidence of this. Underlying such discussions are fundamental issues of control and consent. Under the rubric of control one thinks of prob-

lems arising from prenatal diagnosis, screening for genetic diseases, artificial insemination, in vitro fertilization, contraception, sterilization, and abortion. Further along the chronological trajectory, there is the control of disease chemically, surgically, and technologically (as in transplantation or hemodialysis); and there is behavior modification through the use of drugs, surgery, and various psychotherapies. At the far end of life a host of questions emerge concerning appropriate care for the dying, prolongation of life, euthanasia, suicide, truth-telling, and the definition of death itself. And, for every question arising over the issue of control there is a countervailing question regarding consent—consent for treatment, surgery, research—at the beginning of life, at its prime, and at its end.

These are important issues to physicians and patients alike and they need to be sorted out in the public forum. But there is so much more to the day-to-day practice of medicine that is ethically significant, even ethically problematic, that to focus exclusively on the "big" problems is to limit the discussion unduly. Ethics is primarily an evaluative enterprise. What follows here are some observations and an evaluation of the social, and especially the moral, climate of medical practice today and some suggestions regarding the role of the physician in that climate. First, the climate itself.

Patient expectations are changing today. A more knowledgeable public is entering into the traditional doctor-patient relationship in a fashion unknown even 20 years ago. Patients have a better understanding of the capabilities of medicine, they demand more information concerning the probable results of medical intervention, and they have higher expectations of good results. The authoritarian role of the physician is being challenged by patients who wish to engage in a more egalitarian relationship, while not disputing the technical and clinical skills

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of the physician. Any obstetrician who has practiced for 20 years will recognize this change. Today a pregnant woman wants to discuss natural childbirth, the effect of drugs on the baby, the possibility of having her husband in attendance at the time of delivery and the advantages of nursing her newborn.

On the other side of the doctor-patient relationship, the expectations of physicians-to-be are also changing. Medical students are sensing that they will be expected, as always, to be competent doctors and to acquire the skills and technical expertise requisite to practicing good medicine but that they will increasingly find themselves on the moral firing line as well. This does not mean that physicians must possess superhuman abilities or that they should learn to be all things — medical and moral — to all men. It does mean however that, as we enter what Daniel Funkenstein² has called the "community era" in medicine, the medical field of vision will be widened to include (as it always has at its best) not only disease entities but whole persons as well, and not only whole individuals but persons in communities — persons in relation to others and rooted in social and cultural milieux.

Perhaps the single most significant social consequence of the meteoric rise of medical science to prominence in this country in the past 30 years and the unprecedented proliferation of medical technology more recently is the popular belief in medicine as omnipotent, as possessing a cure for whatever ails the patient. Medicine is seen in millennial terms. Physicians are cast in the role of saviors — expected to "save" lives as well as alleviate pain and cure diseases — and the whole enterprise of medical practice takes on epic chiliastic proportions. There is nothing intrinsically objectionable about such a state of affairs. Much has come to be expected of medicine, and many of those expectations have been and continue to be roundly fulfilled. It is when the inevitable limitations of medicine are overlooked that an exaggerated faith in what can be accomplished emerges. And, as some of the best recent social analyses of technology and science suggest, exaggerated hopes tend to spawn exaggerated disappointments. Dashed expectations often become rancorous. When this happens in the setting of medical practice the very basis of the physician's ability to cure and care — the trust that is built up between a patient and a physician — may be eroded. "What is wanted," as medical writer Berton Rouche said at a recent symposium,³ "is to extricate the doctor from the burden of too great an expectation without at the same time destroying

all confidence in his powers. He must in some delicate and appealing way be relieved of infallibility." Rouche is on to something important here, and I believe that many significant contributions to the process of relieving physicians of their infallibility may be made by physicians themselves or at least by those within the profession who, in their public pronouncements and private utterances, steadfastly resist being either hallowed or villified by patients, press, or public-at-large, and who insist instead on the inviolability of the relationship between doctor and patient. What is the character of that relationship today? I think it is generally characterizable in one of two ways.

There is, on the one hand, a modern version of the ancient and honorable priestly role that the physician assumes in relating to patients. In this role the physician is viewed as having at his command arcane knowledge and technique which, when expertly applied, can ease births, end fevers, and fend off death. Regard for the physician as priest is on the wane today, although significant vestiges of many of the traditional rituals surrounding that regard — the laying on of hands for comfort, and indeed the very naming of the malady itself as a means of controlling and assuaging — are still with us.

On the other hand, the notion of the physician as consultant is rising in prominence. On this view, a physician is a certified expert in a particular, carefully delimited area and his advice and assistance are to be sought by those whose health problems fall within his area of expertise. A patient contracts with a physician for specific services much as one might arrange with a general contractor to have the roof of one's house repaired. Personal interaction is minimal, payment is made for services rendered, and that is that — unless, of course, the services are in some way unsatisfactory, in which case the patient/client files suit for damages!

This last is perhaps a bit overstated but in today's medical-social climate, not much. What I am implying here is simply put: for all the advantages of a doctor-patient relationship construed contractually (I am thinking here primarily of the lowering of patients' expectations; that is, in a contractual relationship the patient does not expect the world and all of the doctor, only that he accurately diagnose and properly treat the patient's particular problem), the disadvantages are potentially devastating. Where there is little rapport, there is much room for dissatisfaction and distrust, and probably also diminished opportunity for effectiveness in treatment.

Medical students worry about locating and adopting an appropriate role for themselves once they begin to practice. And they often despair at the paucity of alternatives. I, for one, applaud the secularization or demystification of medicine as a priestly art, but I find the model of physician as consultant inadequate as a replacement. Doctors as priests were tempted by and fell prey to authoritarianism; doctors as consultants are tempted by and fall prey to indifference.

When a person goes to a doctor he puts himself at that doctor's disposal, makes himself vulnerable, and is to a considerable degree reliant not only on the physician's knowledge of disease and his clinical judgment but also on his moral sense and ethical judgment.* And, although the patient is of course no match for the physician on medical grounds, he too brings with him to this encounter his own moral sense and ethical judgment and some sound notion, perhaps not well-articulated, of what he does and does not want done with and to him. The meeting thus of a doctor and a patient is, I think, more accurately characterized by the term "partnership" than by the term "contract." I do not

mean by "partnership" an inappropriately familiar, "we're-both-in-this-together" relationship, but rather one which is characterized by collaboration, by mutual respect, a joint commitment to "getting well" or getting on, and an authoritativeness (not authoritarianism) on the part of the physician which he possesses by virtue of his education and experience in matters medical.

Ethics, I began by saying, is an evaluative enterprise. What I have wanted to provide here are some remarks that take cognizance of the importance of particular medical ethical issues but which back off from these pointed issues long enough to get a bead on the relationship which is the turning point of them all.

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The Physician's Pathway for Lower Drug Costs

Harry C. Goldberg, M.D.

Among important factors adding to the cost of medical care are medications. The average patient's complaint to his physician is that drugs "cost a lot." That querulous complaint is also an appeal for ways to lower such costs. Unlike the weather about which we can complain but are unable to alter, present drug costs can be substantially lowered. In a recent article in JAMA¹ by a prominent pharmaceutical educator offering facts concerning drug costs and suggestions for helping to control and lower such costs is the statement that we spend about \$8.5 billion/year for drugs. The author emphasizes that physicians tend to ignore the cheaper nonprescription drugs and stresses that communication between the patient, his doctor and his pharmacist is the single most important tool that the patient can use to minimize drug costs. He further recommends that the patient shop carefully for a family pharmacist and stick with him in the same way that he does with his physician.

The frustrated and misinformed patient lumps together all medications in calculating the cost of drugs: (1) drugs ordered by his physician on a prescription blank, (2) drugs which are indeed ordered on a prescription blank but which can be obtained at substantial savings if over-the-counter (O.T.C.) items, i.e., not requiring a "prescription," (3) unneeded drugs which the patient purchases in the supermarket just to have on hand.

In the category of medications requiring prescriptions, the physician can help his patient save money by:

(a) Writing for a drug using its generic name if he feels the quality will be reasonably bioequivalent—and it usually is.²

(b) Jotting down O.T.C. items on the back of a prescription blank or better still on a plain slip of paper. To some patients anything written anywhere on a prescription blank is still a prescription!

(c) Learning that some "prescription" drugs are available O.T.C. at substantial savings if written for in weaker, but still effective strengths, e.g., Chlortrimeton syrup, Triaminicin tablets and spray, Allerest tablets, and many others.

Some O.T.C. preparations are at times not only cheaper but preferable to prescription drugs. For example: Bacitracin, a topical antibiotic ointment, is available O.T.C. and is cheaper and often preferred by many dermatologists to neomycin ointments, which have only recently become available O.T.C.

Carbolated vaseline, accepted by the Food and Drug Administration, is an excellent inexpensive antiseptic ointment. Plain petroleum jelly is an excellent bland ointment and costs a fraction of the cosmetic type emollients. If used properly, i.e., in tiny amounts, it has an excellent patient acceptability.

Small amounts of drugs should be prescribed if they are being used on a trial basis or if tolerance has not been established. Needless to say, the larger the amount ordered the cheaper it will be for the patient. Prices almost always decrease substantially with volume,* but all the while the physician should remember to prescribe only enough medication for the time limits of the disease. There is a tendency, especially with antibiotic ointments, to order one ounce amounts whereas a prescription can be written for a small foil pack (usually sufficient for a dozen applications to a tiny area such as postoperative keratosis, wart, or mole site). For example, Neosporin, a neomycin salve, is available in a 1/32 ounce foil pack and often only this amount is needed! Physicians frequently make these samples available without charge.

It is often helpful if the doctor or his nurse will actually show the patient how to use topical medication or how to apply wet compresses. For example, patients tend to "butter-up" a skin area to be treated, whereas a pea-sized amount is enough to smooth on an area the size of the back of the hand. It is helpful to show patients just how little ointment is needed for an "invisible" application. A \$5, 1/2 ounce steroid cream properly used may be adequate to completely treat a localized lesion whereas many patients will use up to \$25 worth of the same cream for the same purpose. Hydrocortisone creams (Hytone, Cort-Dome, Eldocort, etc.) can be reasonable effective for a fraction of the cost of the more elaborate steroid preparations (Lidex, Valisone, Kenalog, Halog, Synalar, etc.) and should be applied first.³

In addition to the physician's help the patient also can help prevent skyrocketing his own drug costs. There are many "doctors" outside the profession and with the help of "friends" the average patient does a substantial amount of drug buying on his own. For example, a recent visit to a friend's house revealed, on the kitchen table, no less than three different bottles of vitamins. The table also

*The PDR indicates the available package sizes and these are the most economical to order.

displayed a bottle of gelatin capsules "to harden the nails." The latter is commonly considered by dermatologists to have no therapeutic or cosmetic value.

Vitamins are the most misused drugs and patients should be advised to reduce their usage. These preparations should be prescribed only for a specific diagnosis. Vitamins have gained in popularity in two ways. Frequently these are prescribed defensively by the physician. Also the patients themselves, on the doctor-avoidance theory, purchase enormous amounts of vitamins, waste their money and create an unnecessary psychological crutch. For example, an expensive bottle of vitamin E capsules, generally considered of little value, was recently brought to me for information about its use by a patient after purchasing it.

Further, patients are bombarded with an incredible stream of propaganda for sure and rapid cures. Although these products are seldom helpful to the patient's health, they are definitely injurious to his pocketbook. A recent series of articles in a health magazine gave appalling do-it-yourself health advice and kitchen junk recipes. Poor advice in some press articles, T.V. and radio media perpetuates misinformation and poor health practices.

A recent book on organic cosmetics⁴ contained eight sun screen "recipes" of which not one had any real value. Often the layman associates price with high or unusual qualities. Especially in the cosmetic field, this is often quite untrue, e.g., inexpensive simple toilet soaps are usually as good as highly touted specialized soaps and often much safer than the medicated soaps. A recent book on American self-dosage medicines⁵ amplifies in its own way some of the above points of view.

Many F.D.A. regulations boost the cost of drugs to the consumer they are meant to help. Steroid creams, some antibiotic creams, and other prescription drugs should be allowed as O.T.C. items.⁶ Efforts at 100% protection never achieve their purpose and the cost of attempting this is enormous to the consumer.

In the style of the old family practitioner, it may be helpful to have the patient bring the contents, or a list of the contents, of the family bathroom medicine cabinet to the doctor for inspection and advice.

Here is a brief rundown of additional areas in which the patient may improve his health and save on, or eliminate, drug costs:

(1) Mouthwashes are often unnecessary and even harmful for the normal mouth and if the mouth isn't normal, then suitable medical and dental care is needed.

(2) Deodorants, both underarm and general, are overused. Further, many patients are not cognizant of the fact that the use of aerosols, where other methods (and there are many) are as good or better, is a luxurious and expensive method of application to be avoided by cost-conscious people.

(3) Nonbrand O.T.C. products usually cost much less than the O.T.C. brand name products, for example, nonbrand petroleum jelly can be bought at approximately one half the cost of Vaseline Petroleum Jelly.

(4) Laxatives involve more than just money. Medical advice is more important than the concept of a periodic cleansing. To the extent that a laxative may be necessary, an O.T.C. nonbrand type such as milk of magnesia, cascara sagrada tablets or the fluid extract, or even brand names such as Ex-Lax are relatively inexpensive. Cereals such as bran-buds are excellent bulk producers and are also mild stimulants to the bowel.

(5) Simple astringent eye drops⁷ such as Murine or Visine are available O.T.C. The cost of most prescription-type ophthalmic drops is unusually high.

(6) One of the nonprescription dusting powders is plain talcum U.S.P.

(7) Calamine lotion with phenol remains one of the best remedies for sunburn and other types of skin irritation. Tell patients that the best way to apply this to large areas is with a paintbrush!

(8) Many of the sun tan/screen preparations

Table of Less Expensive Alternatives

1. Deodorants	Use liquids or stick types rather than the more expensive aerosols
2. Generics vs Brand Names	Compare brand name vaseline petroleum jelly vs nonbrand name. Brand name aspirin vs generic aspirin
3. Laxatives	Use natural fiber foods, or O.T.C. inexpensive items such as milk of magnesia for occasional use
4. Eye Drops	O.T.C. Visine or Murine
5. Dusting Powders	Plain talc or zinc stearate
6. Protective Lotions	Calamine, plain or with phenol; petroleum jelly
7. Sunscreens	Red veterinary petroleum and paba type preparations
8. The readily available Handbook of Non-Prescription Drugs ⁷	has a complete list of O.T.C. drugs, practically all of which are as good as and usually substantially cheaper than brand name and prescription drugs.

which are available are worthless or potentially harmful. Among those that are effective and protective are Coppertone, PreSun, Pabafilm, Solbar, Uval, and Sundown. The cheapest is red veterinary petroleum.

The doctor's ingenuity applied to the drug cost problem can be of tremendous help to the patient. Many distinctive leaflets, pamphlets, and brochures are available without charge from prestigious sources that correctly inform the patient about problems with which he may be concerned. Once a good rapport is established with a patient, your word should be as effective as your prescription.

A final and important note: Drug samples are supplied to us in large amounts. Patients avidly accept these when the physician makes them available. Since the purchase price of additional amounts of these samples is usually expensive, the patient should be made aware of this fact. Often one or more starter doses, or several samples may be sufficient medication for a minor problem so that no additional cost is involved for the patient. The starter sample makes it easy to determine whether an

expensive and not infrequently upsetting drug will be tolerated by the patient before writing a prescription for it. Griseofulvin is a good example of such a drug. Further, we are not altogether dependent on "samples." Dispensing of drugs by physicians is still carried out, albeit to a much lesser degree than in the past. The economy and the convenience to the patient is readily provided by "giving" the patient some of the inexpensive yet necessary little drug aids for his comfort and welfare without a trip to the drug store.

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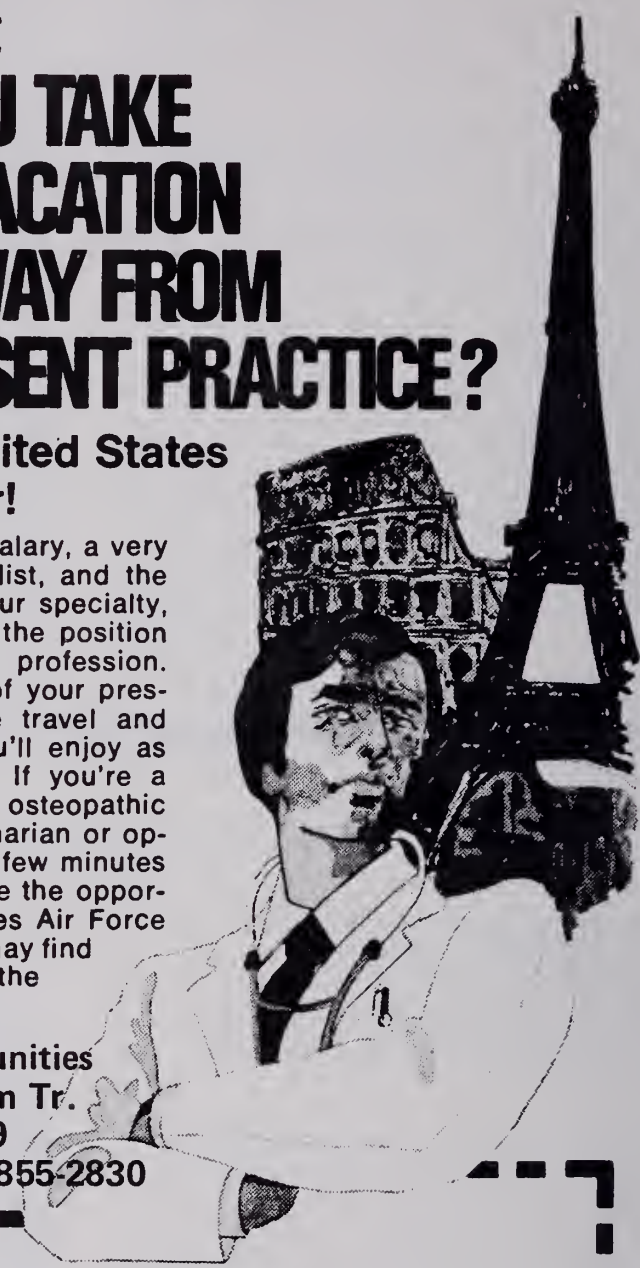
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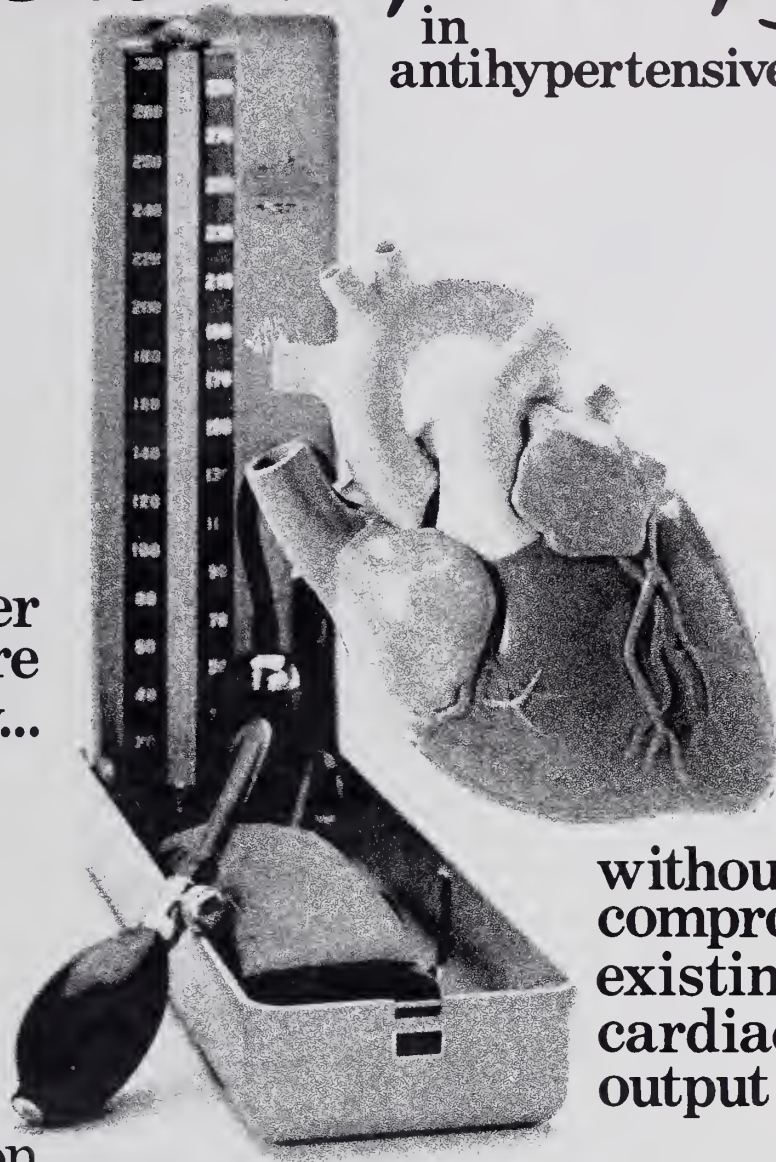
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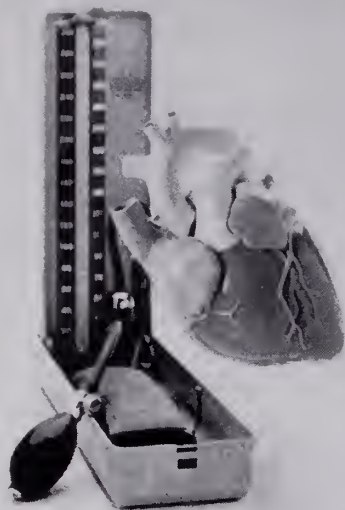
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With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or

cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Use in Pregnancy: Use of any drug in women who are or may become pregnant requires that anticipated benefits be weighed against possible risks; possibility of fetal injury can not be excluded.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decreased mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease daily dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatus, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia. Leukopenia, granulocytopenia, thrombocytopenia.

Allergic: Drug-related fever, myocarditis.

Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, dermatologic reactions including eczema and lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited to 500 mg daily when given with antihypertensives other than thiazides. Tolerance may occur, usually between second and third month of therapy; increased dosage or adding a thiazide frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Syncope in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

How Supplied: Tablets, containing 125 mg methyldopa each, in bottles of 100; Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

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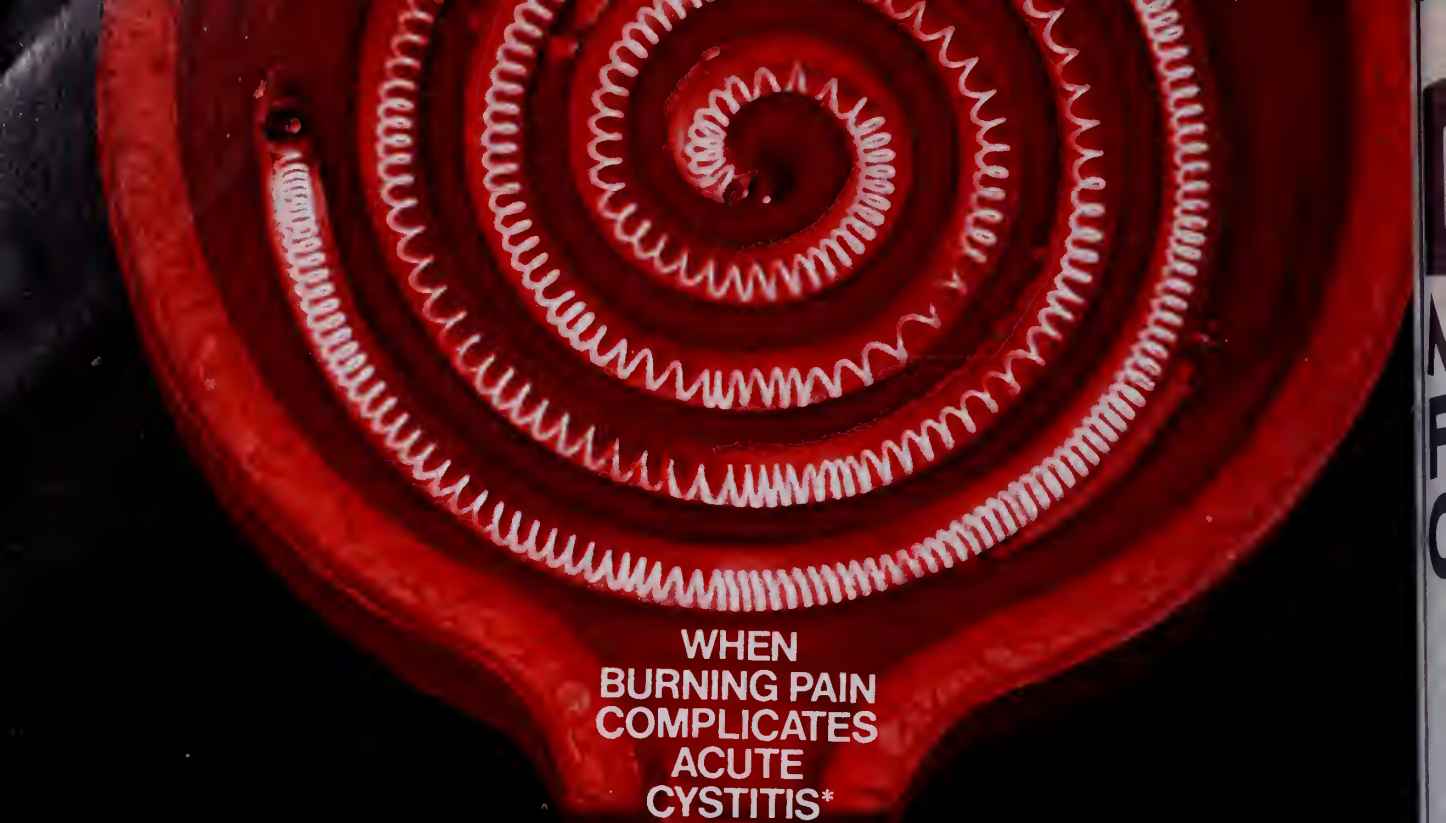
That's why we're offering you the poster shown here. You can hang it on the wall or stand it on a small table. It comes with booklets called "As

precious as sight" that give your patients some basic facts about auditory testing and hearing losses and how easy they are to correct in many cases.

Write to us for your free poster and booklets. They just might help you to help some patients who aren't hearing as well as they used to. Even those who ordinarily wouldn't hear of it.

Professional Relations Division, Beltone Electronics Corporation
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Beltone
WHEN A HEARING
AID WILL HELP



WHEN
BURNING PAIN
COMPLICATES
ACUTE
CYSTITIS*

TURN IT OFF WITH
AZO GANTANOL[®]

Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.

FOR THE PAIN

- Quickly relieves painful symptoms such as burning and pain associated with urgency and frequency.
- Recommended antibacterial therapy: up to 3 days with Azo Gantanol, then 11 days with Gantanol (sulfamethoxazole).

FOR THE PATHOGENS

- Effectively controls susceptible pathogens such as *E. coli*, *Klebsiella-Aerobacter*, *Staph. aureus*, *Proteus mirabilis* and, less frequently, *Proteus vulgaris*.

*nonobstructed; due to susceptible organisms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Aerobacter*, *Staphylococcus aureus*, *Proteus mirabilis*, and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies.

Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: Blood dyscrasias (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura,

hypoprothrombinemia and methemoglobinemia); allergic reactions (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); G.I. reactions (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); CNS reactions (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); miscellaneous reactions (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. Usual adult dosage: 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

ROCHE

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Division of Hoffmann-La Roche Inc.
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DYAZIDE

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® Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE FOR LONG-TERM CONTROL OF HYPERTENSION*

**LOWERS
BLOOD
PRESSURE**

**CONSERVES
POTASSIUM**

Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

WARNING

This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Indications: When the fixed combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium-sparing action of its 'Dyrenium' component is warranted.

Contraindications: Further use in progressive renal or hepatic dysfunction; hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs. Routine use of diuretics in otherwise healthy pregnancy.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with

cardiac irregularities. It is more likely in severely ill patients with urine volume less than one liter/day, the elderly or diabetics, with suspected or confirmed renal insufficiency. Periodic determinations of serum K^+ should be made. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. The presence of a widened QRS complex or arrhythmia in association with hyperkalemia requires prompt additional therapy. Thiazides are reported to cross the placental barrier and appear in breast milk; fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and other adverse reactions that have occurred in the adult may result. When used in pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics, or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spiro-lactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+ . Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium® (triamterene, SK&F Co.), and

leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Do periodic blood studies in cirrhotics to check for nondrug-related variations in blood pictures, and in patients with folic acid depletion, since 'Dyrenium' may contribute to appearance of megaloblastosis. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

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CODEINE COMBINATION PRODUCTS.
YOU MAKE THE CHOICE.**



**EMPIRIN[®]
COMPOUND
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#3**

Each tablet contains:
codeine phosphate, 32 mg (gr ½),
(Warning: May be habit-forming);
aspirin, 227 mg; phenacetin, 162 mg;
and caffeine, 32 mg.



**EMPRACET[™]
c̄ CODEINE
#3**

Each tablet contains:
codeine phosphate, 30 mg (gr ½),
(Warning: May be habit-forming);
and acetaminophen 300 mg.



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ORGANIZATION

Florida Medical Association House of Delegates Called Meeting January 28-30, 1977 Lake Buena Vista First House of Delegates

The First House of Delegates convened at 2:15 p.m. on Friday, January 28, 1977, at the Dutch Inn, Lake Buena Vista, with Dr. Charles J. Kahn, Speaker of the House presiding.

The invocation was given by Dr. Thomas B. Thames, Orlando.

Dr. Herbert E. Brooks, Chairman of the Credentials Committee, reported that 197 delegates were present and that 37 counties were represented, constituting a quorum, and moved that the delegates be seated. The motion carried.

Delegates

ALACHUA—Owen F. Agee, Daniel B. Cox, William B. Deal, William V. Pfaff, Gerold L. Schiebler, James C. Campbell, Student (Absent—Mark V. Barrow, Thomas D. Bartley).
BAY—John F. Mason, Jr., Clark Whitehorn.
BREVARD—Harold Albert, Lewis A. Bean, James E. Carter, Michael Foley, Laudie E. McHenry (Absent—William J. Broussard).
BROWARD—Robert J. Brennan, Andre S. Capi, Willis N. Dickens, Burns A. Dobbins, Arthur L. Eberly, William M. Glantz, Theodore W. Hahn, Rupert S. Hughes, James A. Jordan, David C. Lane, Ray E. Murphy, Franklin B. Ott, Ray E. Parks, James B. Perry, Thomas Francis Regan, Joseph M. Sachs, Robert M. Segaul, David S. Teperson, Anthony J. Vento, William D. Wells, Juan Wester (Absent—Bruce B. Burgess, George P. Messenger, James Redd).
CAPTIAL—Robert P. Johnson, Nelson H. Kraeft, Jack W. MacDonald, Robert N. Webster.
CHARLOTTE—Melvyn Katzen (Absent—Fred P. Swing).
CITRUS—HERNANDO—Wilburn R. Jenkins.
CLAY—Laurin G. Smith.
COLLIER—Nicholas H. Kalvin, Robert Wald.
COLUMBIA—Barney E. McRae.
DADE—Edward R. Annis, Rufus Broadaway, Luis A. Cabrera, Sol Center, Jack Q. Cleveland, Vincent P. Corso, Oliver W.

Davenport, Miguel Figueroa, Ivor Fix, Richard M. Fleming, L. Marshall Goldstein, Julian H. Groff, Stephan Glucroft, Abraham Gurinsky, Henry C. Hardin, Joseph Harris, Norman M. Kenyon, Stanley D. Mitchel, Thomas J. Noto, Jorge R. Pena, Walter W. Sackett, Edward St. Mary, Samuel P. Stokley, Mario M. Stone, William M. Straight, Charles F. Tate, John C. Turner, E. W. Webb, Arthur Wood, Jr. Sheldon Zane (Absent—Joseph Amdur, William G. Aten, Edmund Cava, Richard C. Clay, Joseph H. Davis, Victor D. Dembrow, Richard Dever, Charles A. Dunn, Issac Egozi, Franklin J. Evans, Augusto Fernandez-Conde, Humberto L. Fontana, N. Ralph Frankel, Milton S. Goldman, Norman L. Gottlieb, Pedro J. Greer, Leo Grossman, Raul Galliano, Walter C. Jones III, James R. Jude, Robert B. Katims, Harold S. Kaufman, Banning G. Lary, Carlos G. Llanes, Rose E. P. London, Moises Mitrani, Miguel A. Mora, Modesto M. Mora, Wesley S. Nock, Harold G. Norman, Oscar S. Sandoval, Robert J. Schiess, Everett Shocket, Margaret Skinner, Chauncey M. Stone, Dale Venning, Student).

DESOTO—HARDEE—GLADES—Clavin W. Martin.

DUVAL—Samuel J. Alford, Warren M. Barrett, William P. Booras, James L. Borland, Yank D. Coble, Patricia C. Cowdery, Wilbert L. Dawkins, Charles P. Hayes, Walton G. Jarrell, John C. Kruse, Charles B. McIntosh, Robert K. Middlekauf, Faris S. Monsour, Daniel B. Nunn, Guy T. Selander, William D. Walklett (Absent—Clyde Collins).

ESCAMBIA—William R. Bell, Eric F. Geiger Theodore J. Marshall, Nell W. Potter, John H. Whitcomb, Henry M. Yonge.

FRANKLIN—GULF—Joseph P. Hendrix.

HIGHLANDS—Donald C. Hartwell (Absent—Glenn V. Hough).

HILLSBOROUGH—Francis C. Coleman, Robert J. Courtney, Irving M. Essrig, John C. Fletcher, Richard S. Hodes, Donald W. Irvine, Victor H. Knight, Aaron Longacre, Thomas E. McKell, William M. Myers, John K. Petrakis, Ralph M. Stephan, William W. Trice, Harold L. Williamson.

INDIAN RIVER—Donald Ames, Ferdinand F. Becker.

LAKE—Bergon F. Brokaw, Thomas D. Weaver.

LEE—Larry P. Garrett, John S. Hagen, Francis L. Howington, H. Quillian Jones.

MADISON—(Absent—Albertus F. Harrison).

MANATEE—Walter B. Graham, John D. Lehman, Roger A. Meyer (Absent—Robert E. King).
 MARION—Claude B. Henderson, Samuel L. Renfroe.
 MARTIN—Fred S. Carter (Absent—Frederick Krauskopf).
 MONROE—(Absent—Ronald H. Chase, William M. Whitley).
 NASSAU—Theodore G. Panos.
 OKALOOSA—William W. Thompson, Eugene R. Valentine.
 ORANGE—Clarence C. Bailey, Stephen A. Butler, Manuel Coto, Clarence M. Gilbert, Paul C. Harding, Rufus M. Holloway, G. Brock Magruder, Joseph G. Matthews, James F. Richards, James J. Schoeck, Thomas B. Thames (Absent—Michael D. Ballard, Robert B. Trumbo, Harry L. Tucker).
 OSCEOLA—George A. Gant.
 PALM BEACH—Carl E. Andrews, Vernon B. Astler, Jerry F. Cox, James R. Forlaw, Luis R. Guerrero, Doris E. Lake, V. A. Marks, Charles E. Metzger, Richard B. Moore, Reginald J. Stambaugh, Arthur Trask, Dick L. Van Eldik, Harold Yount.
 PANHANDLE—Herbert E. Brooks, William F. Brunner.
 PASCO—Nessan McCann.
 PINELLAS—Emil E. Burns, Thomas M. Daniel, Charles K. Donegan, John M. Hamilton, Kay Hanley, David S. Hubbell, Morris J. LeVine, William F. Mallette, James H. Miller, James M. Neill, Donald G. Nikolaus, David T. Overbey, Walter H. Winchester, Rowland E. Wood (Absent—David O. Westmark).
 POLK—Salvadore J. Barranco, Tom Caswall, J. Gerard Converse, Frank J. Fischer, John W. Glotfelty, William E. Manry, Paul A. Tanner, Franklin Zeller, Jr.
 PUTNAM—(Absent—Iftikhar Ahmad).
 ST. JOHNS—Wayne O'Connell.
 ST. LUCIE—OKEECHOBEE—William H. Meyer (Absent—Howard C. McDermid).
 SANTA ROSA—(Absent—William N. Watson).
 SARASOTA—John N. Carlson, Kenneth C. Kiehl, Douglas R. Murphy, Franklin Pfeifferberger, Karl R. Rolls (Absent—Samuel Kaplan).
 SEMINOLE—Clyde Meade (Absent—Vann Parker).
 SUWANNEE—HAMILTON—LAFAYETTE—Laurent V. Radkins.
 TAYLOR—John H. Parker.
 VOLUSIA—Michael Fronstin, Irwin Leider, Richard W. Snodgrass, James White (Absent—John Morris).
 WALTON—(Absent—Howard F. Currie).
 SPEAKER OF THE HOUSE—Charles J. Kahn.
 VICE SPEAKER—Sanford A. Mullen.

Upon motion duly carried, the Rules and Order of Business of the House were adopted as follows:

Information for Delegates

The Rules and Order of Business for the Called Meeting of the House of Delegates is included in this packet.

Delegates whose names appear in this packet are those seated at the 1976 Annual Meeting. Replacements must be certified by their county medical societies. Our By-Laws do not permit an alternate to serve for a delegate who has once been seated. The By-Laws require that delegates fill out attendance cards at **each meeting** of the House of Delegates in order to be credited in attendance, and further, the chairman of the Credentials Committee is required to report to the House the number of delegates who have registered their attendance cards, thus eliminating the necessity of a roll call to seat delegates.

Reports and/or recommendations to be considered during the Called Meeting are included in this packet. Delegates are urged to study them carefully before they are introduced in the House.

All reports will be referred to Reference Committees by the Speaker at the First Meeting of the House of Delegates. All members who are interested in any report should attend the Reference Committee meetings where a full discussion will take place. All members of Reference Committee meetings are urged to study carefully the reports referred to them. The chief purpose of the Reference Committees is to allow an opportunity for as many members of the Florida Medical Association as possible to appear and be heard and thus have a voice in the business of the Association. In addition, discussions before the Reference Committees have the added advantage of avoiding long discussions at the meetings of the House of Delegates.

All reports included in this packet have been color coded for easy reference. This color code is as follows:

REFERENCE COMMITTEE NO. I — PINK

REFERENCE COMMITTEE NO. II — BLUE

Your Speaker and Vice Speaker are available at any time in any capacity in which they might help any member of the Florida Medical Association.

Charles J. Kahn, Speaker

House of Delegates

Sanford A. Mullen, Vice Speaker

House of Delegates

The Speaker introduced the officers of the Association: Drs. Jack A. MaCris, President; Louis C. Murray, President-Elect; Vernon B. Astler, Immediate Past President; O. William Davenport, Vice President; Robert E. Windom, Secretary; Richard S. Hodes, Treasurer; Charles J. Kahn, Speaker, Sanford A. Mullen, Vice Speaker; W. Harold Parham, D.H.A., Executive Vice President.

The Speaker then instructed the House.

Remarks of the Speaker

President MaCris, Officers of the FMA and fellow delegates, I would like to take this opportunity on behalf of members of the FMA to thank you for your attendance at the Called Meeting of the House. Yours is a great responsibility, for the deliberations and decisions of this meeting will significantly affect the careers of your colleagues at home, and further, will significantly affect the welfare of the citizenry of the State of Florida. I want to urge all of you to attend the Reference Committee Meetings and participate in the discussions. Your input is vitally needed. Only by consideration of diverse opinions can a true position of unity be achieved. The Vice Speaker and I will be happy to assist any delegate or any delegation during the meeting, whenever and wherever possible. I would also like to thank the House for affording me the great honor of being here as your Speaker. With you patience and indulgence and a reliance on the words of wisdom of the Sturgis Standard Code, we shall try to endeavor to justify your trust. Thank you.

The Speaker announced the Chairmen of the Reference Committees and their members and noted the changes that had been made in the Reference Committee personnel.

Reference Committee No. 1 — Legislation

R. Ben Moore, M.D., Chairman

Paul C. Harding, M.D.

Victor Knight, M.D.

Barney McRae, M.D.

David Overbey, M.D.

Reference Committee No. II — Miscellaneous Business

Vincent Corso, M.D., Chairman

O. Frank Agee, M.D.

Dick Van Eldik, M.D.

Charles Hayes, M.D.

Henry Yonge, M.D.

Dr. MaCris called on Dr. Jere Annis for a special AMA Award of Merit for Outstanding Service to American Medicine, presented to W. Harold Parham, D.H.A., by Jere Annis, M.D., Vice Chairman, AMA Board of Trustees.

Dr. Annis: Thank you Dr. MaCris, Mr. Speaker—
In these dark, dismal and often desperate days that tend to surround medicine today, with the professional liability crisis, and all our other adversaries - ranging from the Department of Health and Welfare, chiropractors, the Federal Trade Commission and the Church of Scientology - it is really refreshing to get an assignment in organized medicine that is a pure joy and pleasure, and I have one today.

As Vice Chairman of the Board of the AMA, the Board has asked me to make a presentation to Dr. Harold Parham, your Executive Vice President, and it is a pleasure to do so. As a matter of fact, I don't recall being as happy about anything in organized medicine since I had the privilege as President of the FMA some 19 years ago, being directed by the Board of Governors, to inform Harold that he had been appointed Chief Administrative Officer of our Association. That time and this moment are two ends of the scale and they are both high points in my life. Obviously, that Board had a lot of vision and did a hell of a good job - either by luck or by careful selection, we arrived at the right solution.

Harold, as you know, has been honored without exception by verbal tribute by every single President of this organization since he joined us in 1949.

We are extremely indebted to him — all of us who have worked with him and of course, this House as well. As you know, he was made a Doctor of Health Administration by the University of Florida and he has had many, many other honors.

At this time I am really happy to give him an honor from the American Medical Association, which he has affected and served so well. Harold, incidentally, was responsible in helping to form the American Association of Medical Society Executives/Advisory Committee to the Executive

Vice President of the AMA when he and Dr. Bert Howard put this together. At that time Harold was President of the American Association of Medical Society Executives. He served as the first Chairman of the Advisory Committee and as a member for the maximum term of six years from 1969 on, and at this time the Board of Trustees, and particularly the Executive Vice President, Dr. Sammons, wishes to present him this plaque in commemoration and commendation of the tremendous work he has done for medicine all over the country, not just in Florida. He has been a model medical executive and we commend him for it.

Harold, we are proud of you and we hope you are as proud of this award.

Dr. Parham: Thank you very much for this honor, it is deeply appreciated.

The President advised the House that the purpose of the Called Meeting was to consider the FMA's legislative program and also to hear reports that would inform the House regarding legislation, litigation, public relations, FMA sponsored insurance and finances.

The President then introduced Senator Mallory Horne, Tallahassee FMA Legislative Consultant, who briefed the House on the past legislative session and the passage of the FMA malpractice package.

Senator Horne stated that he was honored to join the FMA team last session and that we have one of the most effective teams anywhere in Harold



W. Harold Parham, D.H.A. (left), Executive Vice President of FMA, displays a plaque presented to him by the American Medical Association Board of Trustees and AMA Executive Vice President James H. Sammons, M.D. Dr. Parham was cited for his outstanding contributions to medicine throughout the country. The presentation was made during the first session of the House of Delegates by Jere W. Annis, M.D., of Lakeland (right), Vice Chairman of the AMA Board of Trustees.

Parham and Scotty Fraser and the entourage of committed physicians in Florida. He briefly reviewed the last session as to where we started and where we wound up. In the first meeting with the Senate Commerce Committee, it was announced that risk management, and nothing else, was the legislative goal of the session and wiped off the calendar the entirety of our program. From there we had to regroup to get our package through. The Florida Legislature did enact a comprehensive medical liability law the last day of the Legislature on June 4, 1976, and it became law on June 27. The Professional Liability Legislation which was enacted included the following provisions of the FMA Professional Liability Legislative Program: structured pay-out of future damages, definition of medical professional negligence, application of collateral sources in jury trials as a direct offset, to prohibit use of *res ipsa loquitur* doctrine in professional negligence actions, a mandatory patients compensation fund, extension of the Joint Underwriting Association beyond its current three year life and compulsory professional liability insurance for all physicians practicing in hospitals. To get this Professional Liability Package passed was an in and out battle. We had to meet with the trial lawyers to try to negotiate a bargain and we sat for hours and hours and hours trying to carve out a position to which we could both give allegiance, and do to the impossibility of that we began in our separate ways to pursue the best hold we could get. This ranged from approximately 35% of our total program until the very last hours of the session and in these last hours this team that represented you was able, on a one-on-one basis, to put the program over the top, and gave us the model program in the country. Senator Horne stated that the physicians that served on an almost daily basis were honorable beyond any expectations and that when offers were made to trade off or double deal, our team remained steadfast. Senator Horne thanked the House for the opportunity of addressing them.

Dr. MaCris commented that the Risk Management concept was not the Florida Medical Association's proposal and was not its doing, but that it was the concept of one senator who was dedicated to seeing its passage and who felt that it would help solve the problem. Dr. MaCris reiterated that the FMA played no role in the matter insofar as its accomplishment was concerned.

The President then introduced Senator Jack Mathews of Jacksonville to address the House regarding litigation. During the past year Senator Mathews has represented the FMA in the Florida Supreme Court and the U.S. Supreme Court in the

litigation involving the Florida medical mediation law.

Senator Mathews stated that once you have a satisfactory product, the war is not over because invariably someone who does not like the product is going to challenge it in court. Therefore, it came as no surprise that in July 1975 some corrective legislative that the FMA sponsored, including the medical mediation panel requiring malpractice cases to be submitted to a panel before going to court, was challenged by the trial bar of the State in the case of "Sparkman vs. Carter". A suit was filed in circuit court against the doctor and his insurance company claiming that the mediation panel was an unconstitutional infringement on the right of trial by jury, a denial of equal protection of the law and a denial of due process. The circuit judge dismissed the suit on the grounds that the plaintiff had not followed the Florida law by in so doing, constitutional questions were raised as to whether the requirement that you had to go through a medical mediation panel before going to court could pass the constitutional test or not, and the judge certified these questions to the Supreme Court of Florida. Until that time the FMA had not taken an active part in the lawsuit, but it was now apparent that the case was important to obtain guidelines for future legislation that would be proposed by us in ensuing sessions of the legislation. Senator Mathews was asked by the FMA to represent them as *Amicus Curiae*, since the doctors of Florida had such a large stake in the case, to set forth their views and to defend the constitutionality of the act. The Supreme Court of Florida, in a case which is cited throughout the country, found in a unanimous decision that the medical mediation panel was not an infringement on the constitutional rights of the people who were injured because they would have to go through a medical mediation panel before going to court. The trial lawyers at this time filed a petition in the Supreme Court of the United States asking the court to issue a Writ of Certiorari to the Supreme Court of Florida that it was wrong and that the 1975 Florida Malpractice Act violated the Constitution of the United States. The FMA wished to be represented in the Supreme Court of the United States and requested me to check with the attorney representing the doctor to determine the best procedure. We found that the insurance company, which had hired the attorney representing the individual doctor, was not too keen in going to the Supreme Court of the United States. We were invited to substitute and come in to take over the main defense of the doctor in the U.S. Supreme

Court and we elected to follow this course. After a study of the briefs, without oral argument, the Supreme Court of the United States unanimously affirmed the decision of the Supreme Court of Florida. Having lost this case, the trial lawyers tried another case in Miami in which my firm is involved on behalf of the FMA. This was a case wherein the Plaintiff requested a mediation panel and then refused to put on evidence in the mediation trial. The circuit judge dismissed the suit and stated that testimony would have to be presented before the medical mediation panel first. This suit is now being appealed in the Third District Court of Appeals in Miami, and will likely be appealed from that decision to the Supreme Court of the United States. Senator Mathews advised that his firm had again entered as Amicus Curiae. While the FMA is not directly involved in the suit brought in behalf of the Joint Underwriters Association and the Patients Compensation Fund, Senator Mathews advised they would be affected by the suit, and this case is set for circuit court on February 25. The trial lawyers have filed a motion to enter the suit as Amicus Curiae and that in this case they are on our side in trying to do away with the Risk Management plan. This concluded Senator Mathews' remarks on mediation panels and risk management.

Dr. MaCris noted at this point that a Mailgram had been sent out regarding Risk Management which offered some guidelines and options. He also noted that the issue was in the courts at the present time and therefore there was little to be done at this moment.

The President introduced Dr. Vernon B. Astler, FMA Public Relations Officer, to address the House regarding the FMA Public Relations Program. Dr. Astler used a slide presentation to review some of the accomplishments of the newly established Public Relations Department had during the past year. Major items covered were the In-Depth Survey which indicated that 76% of the public felt they were getting top-notch medical care and 50% felt they were receiving the best health care in the world; a comprehensive advertising campaign to support the Professional Liability program; PR themes that had been developed for publication including a newspaper column that was now being co sponsored by 18 County Medical Societies and also in 77 newspapers including some Class I dailies; the statewide news conference held during the legislative session last year and the two Television Public Service Announcement releases. The FMA-produced 30-minute television program "A Matter of Life" was also shown to the House. Dr. Astler

noted that this was only the beginning for a Public Relations program; that it has to be an ongoing thing and that we may not have the results of this effort for four or five years. Dr. Ed Annis was commended for his part in the television documentary. Dr. Astler noted that a poll was taken after the documentary was shown on television and called FMA Public Relations Consultant, Mr. Roy Pfautch of Civic Services, St. Louis, Missouri to the podium to address the House regarding the PR Program and the poll.

Mr. Pfautch commended Dr. Astler for his foresight in going to the public with the message of health care in Florida, and the television documentary. Mr. Pfautch addressed the House on the two images of physicians; their collective image which is the one on the front page of the newspapers, and their individual image which is the one created everytime they reach out and touch another individual. He noted that very few professional associations in this country are sophisticated enough to understand the strength of the personal image over the collective image. It is the personal that wins the day every time and the problem in Florida medicine is how to extend the personal image into the collective one. Mr. Pfautch noted that many of the programs commented on by Dr. Astler were long range programs due to the fact that they could never get rid of the problems of the collective image — the front page attack. The public responds to the personal image or individual image and not the front page image and it is to that image that the PR Department has appealed in the past year, stated Mr. Pfautch. The goal for 1977 is to consolidate the foundation of last year and to take the lead in current events and to be ahead of the news. Mr. Pfautch outlined some new possibilities that could be tried in 1977, such as a Statewide



Rep. Otis G. Pike (Dem.-N.Y.) (right) was the guest speaker for the FLAMPAC Luncheon, held in conjunction with the Called Meeting of the House of Delegates. Here, Congressman Pike chats with FMA President-Elect Louis C. Murray, M.D., of Orlando.

Speaker's Bureau and the development of an Opinion Leader Index. After the television documentary was shown on January 25th, various polls were taken and Mr. Pfautch announced the following results of the polls: 30% of the people in Florida watching television on January 25th saw the program "A Matter of Life"; over 95% found the film interesting and 48% rated the film as excellent; 51% said they would like to see it again and the norm for this would be in the 20% bracket; 70% felt that Florida had one of the best health care systems in the world and this is a higher percentage than we had in 1975; 88% said they trusted, respected and had confidence in their physicians. What we are trying to do in the FMA 1977 Public Relations Program, said Mr. Pfautch, is to depict the individual commitment of each person in the room to extend the image portrayed in the film, the individual image, and make it the collective image of the physician and medical care in Florida.

Dr. MaCris then introduced Dr. James W. Walker, President of PIMCO, to comment on the FMA sponsored insurance program. Dr. Walker advised the members of the house that a brochure had been prepared outlining the purpose and functions of PIMCO and was in their packets. A slide presentation was used along with the brochure to explain the Florida Physicians' Insurance Reciprocal, the FMA-PLI-TRUST, FMA Insurance Plans and PIMCO. Dr. Walker noted that the Florida Physicians' Insurance Reciprocal insurance plan is a model for the nation, and has the lowest overhead of any physician owned plan in America.

Dr. MaCris then called upon Dr. Richard Hodes, Treasurer, to address the House regarding FMA

Finances.

Dr. Hodes used a slide presentation to advise the House of the general categories of FMA expenditures during the past year. These included Harlan-Med, Inc., the purchase of the Capital Office, Building in Tallahassee, equipment, contract services, headquarters operations, the assessment, Public Relations, the legislative program and expenses for committee meetings, Board Meetings etc.

Dr. MaCris announced that this concluded the reports and invited all to attend the General Session on Saturday at 2:00 p.m.

The Speaker thanked Dr. MaCris, on behalf of the House, for making the House the best informed House of Delegates during his fourteen years as a Delegate.

The Vice Speaker announced the meetings of the Reference Committees on Saturday, January 29, and the time and place of each meeting:

Reference Committee I — Legislation

9:00 a.m., Netherlands Room A

Reference Committee II — Miscellaneous Business

9:00 a.m., Netherlands Room B

Dr. Kahn, the Speaker, announced that he had been advised by the President of his intent to present a special report in the latter portion of the second meeting of the House on Sunday in Executive Session. Only Delegates would be in the meeting and some specially invited participants, due to the sensitive nature of some of the reports.

The House recessed at 4:30 p.m., to meet again at 9:00 a.m. on Sunday, January 30.

General Session

The General Session was called to order at 2:00 p.m., on Saturday, January 29, 1977, in the Netherlands Room, Dutch Inn, Lake Buena Vista, by President Jack A. MaCris, M.D.

Dr. MaCris updated the House on priority items during the year. Areas covered were communications with members, the public relations program, coordination of legislative activities with county medical societies, active support of FLAMPAC, statewide health planning activities, establishment of a statewide peer review organization in the private sector, the emergency medical service program and continued efforts in the areas of physician availability and cost of medical care in nursing homes.

The President introduced Dr. William W. Thompson, chairman of the Judicial Council, who

commented on some major areas covered by the Council during the year — telephone directory listings, abortion problems, free standing laboratories, pending legislation, and the bylaws amendment allowing osteopaths FMA membership.

Dr. James F. Richards, Jr., chairman of the Council on Medical Economics, reported on that Council's two committees — the Committee on Relative Value Studies, and the Committee on Health Insurance. Numerous meetings were held during the year to explain the 1975 RVS, and the Committee worked with Blue Shield to develop a physicians' manual outlining Blue Shield policies and procedures. The Committee on Cost of Medical Care has implemented several pilot studies, with Blue Cross and Blue Shield, hospitals and insurance companies participating.

Dr. James B. Perry, chairman of the Council on Legislation and Regulations, advised the House that personal contact is the key, and active participation is vital for a successful legislative program.

Dr. J. Russell Forlaw, chairman of the Council on Medical Services, reported that several statewide conferences have been sponsored by the Florida Medical Foundation, and a variety of studies conducted in Health related problems. Newspaper reports indicate that Florida leads the nation in the area of emergency medical services. Efforts to increase state funding for county health departments continue, and the study has been completed on availability and utilization of medical services by Florida's 29 residential drug abuse treatment centers.

Dr. James L. Borland, chairman of the Council on Medical Systems, commented on the activities of

the four committees of the Council — PMUR, which performs utilization review for Medicare; Hospitals and Extended Care Facilities, whose seminar on "The Role of the Medical Director in the Skilled Nursing Facility" was rated by the AMA as the best in the country; Foundations for Medical Care, which keeps tabs on PSRO; and Government Programs, who monitors legislation pertaining to medicine.

Dr. Lee Dockery, chairman of the Council on Scientific Activities, commented on the highlight activities of its four committees: Scientific Publications, Continuing Medical Education, Medical Education, and Research. Dr. Murray, President-Elect, stated that the 1977 Scientific Winter Assembly will be held in Florida this year, and that this Council will be responsible for the program.

The General Session adjourned at 3:30 p.m.

Second House of Delegates

The second meeting of the House of Delegates convened at 9:15 a.m., Sunday, January 30, 1977, at the Dutch Inn, Lake Buena Vista, Florida, with Dr. Charles J. Kahn, Speaker of the House presiding.

Dr. Herbert E. Brooks, Chairman of the Credentials Committee, reported that 203 Delegates were present, constituting a quorum and that a majority of counties (38) were represented. Dr. Brooks moved that the delegates be seated. The motion carried.

Delegates

ALACHUA—Owen F. Agee, Mark V. Barrow, Thomas D. Bartley, Daniel B. Cox, William B. Deal, Gerold L. Schiebler, James C. Campbell, Jr., Student (Absent—William W. Pfaff).
BAY—John F. Mason, Jr., Clark Whitehorn
BREVARD—Harold Albert, Lewis A. Bean, William J. Broussard, James E. Carter, Michael Foley, Laudie E. McHenry.
BROWARD—Robert J. Brennan, Bruce B. Burgess, Andre S. Capi, Willis N. Dickens, Burns A. Dobbins, Arthur L. Eberly, William M. Glantz, Theodore W. Hahn, Rupert S. Hughes, James A. Jordan, George P. Messenger, Ray E. Murphy, Franklin B. Ott, Ray E. Parks, James Redd, Thomas F. Regan, Joseph M. Sachs, Robert M. Segaul, David S. Teperson, Anthony J. Vento, William D. Wells, Juan Wester (Absent—David C. Lane, James B. Perry).
CAPITAL—Robert P. Johnson, Nelson H. Kraeft, Jack W. MacDonald, Robert N. Webster.
CHARLOTTE—Melvyn Katzen, (Absent—Fred P. Swing).
CITRUS-HERNANDO—Wilburn R. Jenkins.
CLAY—Laurin G. Smith.
COLLIER—Nicholas H. Kalvin, Robert Wald.
COLUMBIA—Barney E. McRae.
DADE—Edward R. Annis, Luis A. Cabrera, Edmund Cava, Sol Center, Vincent P. Corso, Oliver W. Davenport, Joseph H. Davis, Franklin J. Evans, Miguel Figueroa, Richard M. Fleming, Ivor Fix, Humberto L. Fontana, Raul Galliano, Stephen Glucroft, L. Marshall Goldstein, Julian H. Groff,

Abraham Gurinsky, Henry Carter Hardin, Joseph Harris, Robert B. Katims, Norman M. Kenyon, Stanley D. Mitchel, Thomas J. Noto, Jorge R. Pena, Walter W. Sackett, Everett Shocket, Edward W. St. Mary, Samuel P. Stokley, Mario M. Stone, William M. Straight, Charles F. Tate, John C. Turner, E. W. Webb, Arthur Wood Jr., Sheldon Zane (Absent—Joseph Amdur, William G. Aten, Rufus Broadaway, Richard C. Clay, Jack Q. Cleveland, Victor D. Dembrow, Richard Dever, Charles A. Dunn, Isaac Egozi, Augusto Fernandez-Conde, N. Ralph Frankel, Milton Goldman, Norman L. Gottlieb, Pedro J. Greer, Leo Grossman, Walter C. Jones III, James R. Jude, Harold S. Kaufman, Banning G. Lary, Carlos G. Llanes, Rose London, Moises Mitrani, Miguel A. Mora, Modesto M. Mora, Wesley S. Nock, Harold G. Norman, Oscar S. Sandoval, Robert J. Schiess, Margaret Skinner, Chauncey M. Stone, Dale Venning, Student).

DESOTO-HARDEE-GLADES—Calvin W. Martin.

DUVAL—Samuel J. Alford, Warren M. Barrett, William P. Booras, James L. Borland, Yank D. Coble, Clyde Collins, Patricia C. Cowdery, Wilbert L. Dawkins, Charles P. Hayes, Walter G. Jarrell, John C. Kruse, Charles B. McIntosh, Robert K. Middlekauf, Faris S. Monsour, Guy T. Selander, William D. Walkett (Absent—Daniel B. Nunn).

ESCAMBIA—William R. Bell, Eric F. Geiger, Theodore J. Marshall, Nell W. Potter, John H. Whitcomb, Henry M. Yonge.

FRANKLIN-GULF—Joseph P. Hendrix.

HIGHLANDS—Donald C. Hartwell (Absent—Glenn V. Hough).

HILLSBOROUGH—Francis C. Coleman, Robert J. Courtney, Irving M. Essrig, John C. Fletcher, Richard S. Hodes, Donald W. Irvine, Victor H. Knight, Aaron Longacre, Thomas E. McKell, William M. Myers, John K. Petrakis, Ralph M. Stephan, William W. Trice, Harold L. Williamson.

INDIAN RIVER—(Absent—Donald Ames, Ferdinand F. Becker).

LAKE—Bergon F. Brokaw, Thomas D. Weaver.

LEE—Larry P. Garrett, John S. Hagen, Francis L. Howington (Absent—H. Quillian Jones).

MADISON—(Absent—Albertus F. Harrison).

MANATEE—Walter B. Graham, Robert E. King, John D. Lehman, Roger A. Meyer.

MARION—Claude B. Henderson, Samuel L. Renfroe.
 MARTIN—Fred S. Carter (Absent—Frederich Krauskoph).
 MONROE—(Absent—Ronald H. Chase, William M. Whitley).
 NASSAU—Theodore G. Panos.
 OKALOOSA—William W. Thompson, Eugene R. Valentine.
 ORANGE—Clarence C. Bailey, Stephen A. Butler, Manuel Coto,
 Clarence M. Gilbert, Paul C. Harding, Rufus M. Holloway,
 G. Brock Magruder, Joseph G. Matthews, James F. Richards,
 James J. Schoeck, Thomas B. Thames, Robert B. Trumbo
 (Absent—Michael D. Ballard, Harry L. Tucker).
 OSCEOLA—George A. Gant.
 PALM BEACH—Carl E. Andrews, Vernon B. Astler, Jerry F. Cox,
 James R. Forlaw, Luis R. Guerrero, Doris E. Lake, V. A.
 Marks, Charles E. Metzger, Richard B. Moore, Reginald J.
 Stambaugh, Arthur Trask, Dick L. Van Eldik, Harold Yount.
 PANHANDLE—Herbert E. Brooks, William F. Brunner.
 PASCO—Nessan McCann.
 PINELLAS—Emil E. Burns, Thomas M. Daniel, Charles K.
 Donegan, John M. Hamilton, Kay Hanley, David S. Hubbell,
 Morris J. LeVine, William F. Mallette, James H. Miller, James
 M. Neill, Donald G. Nikolaus, David T. Overbey, Walter H.
 Winchester, Rowland E. Wood (Absent—David O.
 Westmark).
 POLK—Tom Caswall, J. G. Converse, Frank J. Fischer, John W.
 Glotfelty, Willard E. Manry, Paul A. Tanner, Franklin Zeller, Jr.
 (Absent—Salvatore J. Barranco).
 PUTNAM—(Absent—Iftikhar Ahmad).
 ST. JOHNS—Wayne O'Connell
 ST. LUCIE-OKEECHOBEE—William H. Meyer (Absent—
 Howard C. McDermid).
 SANTA ROSA—(Absent—William N. Watson).
 SARASOTA—John N. Carlson, Samuel Kaplan, Kenneth C.
 Kiehl, Douglas R. Murphy, Franklin Pfeifferberger, Karl R.
 Rolls
 SEMINOLE—Vann Parker (Absent—Clyde Meade).
 SUWANEE-HAMILTON-LAFAYETTE—Laurent V. Radkins.
 TAYLOR—John H. Parker.
 VOLUSIA—Michael Fronstin, Irwin Leider, John Morris, Richard
 W. Snodgrass (Absent—James White).
 WALTON—(Absent—Howard F. Currie).
 SPEAKER OF THE HOUSE—Charles J. Kahn.
 VICE SPEAKER—Sanford A. Mullen.

The Speaker thanked the members for their time and their attendance. He then introduced James C. Campbell, Jr. of Alachua County as the Student Delegate.

Report of Reference Committee

No. 1.

Legislation

The Speaker called for the report of Reference Committee No. 1, Legislation.

Dr. R. Benjamin Moore, Chairman, and his committee came forward to present the report of the Reference Committee:

Dr. Moore: "Mr. Speaker, Mr. President and Members of the House of Delegates:

"Your Reference Committee No. 1 — Legislation has considered each of the items referred to it and presents the following report. The Reference Committee's report on each item will be submitted

separately, and I respectfully suggest that each item be acted upon before going to the next."

REPORT OF THE BOARD OF GOVERNORS

Recommendation No. 1 — Item No. 1

"Your Reference Committee reviewed with interest the proposed program entitled, **A Continued Program to Resolve the Malpractice Crisis In Florida**, and wishes to observe that this document was diligently and skillfully prepared and presented. We congratulate those persons responsible for its draft and construction. We also heard testimony relating that enactment of the bill entitled, **Two Year Statute of Limitations**, would have a stabilizing effect on the rate structure of the Florida Physician's Insurance Reciprocal.

"Mr. Speaker, I move the House of Delegates adopt Item No. 1, Enactment of an Absolute Two-Year Statute of Limitations as Item No. 1 of the Florida Medical Association's Legislative Program for the 1977 session of the Florida Legislature."

The motion carried.

Recommendation No. 1 — Item No. 2

"Mr. Speaker, your Reference Committee studied the proposed legislative bill entitled, **Recovery of Defense Costs**, included in the previously mentioned program. Mr. John Thrasher, FMA Legal Counsel, to our Tallahassee office, reviewed for us the mechanisms and stabilizing effects of such legislation if passed.

"Mr. Speaker, I move the adoption of Item No. 2, Provision for Recovery of Defense Costs in Medical Malpractice Cases, as Item No. 2 for the Legislative Program of the Florida Medical Association for the 1977 session of the Florida Legislature."

The motion carried.

Recommendation No. 1 — Item No. 3

"Mr. Speaker, your Reference Committee reviewed the presentation entitled, **A Program for A Separate Department of Health**, including a draft of a joint resolution of the Florida Legislature designed to create a Cabinet office of Secretary of Health by means of amending the Florida Constitution. We heard testimony from several members of the Association, both those from private practice sector and those in public health, to the effect that the present organization of the State Government of Florida has resulted in health matters being buried in the large bureaucracy of the Department of Health and Rehabilitative Service, subjugated to numerous non-health related social programs. We heard testimony that the cost of this Department, as

now constituted and operating will be enormous when finally realized by the Legislature and the people. We also had presented, by representatives of the Florida Association of County Health Officers, a draft of legislation that that organization proposes to introduce relating to reorganization of the Department of HRS in such a manner as to separate health affairs into a recognizable and workable system of authority and responsibility.

"The Committee considered whether action of the House of Delegates in regard to a position on this latter legislation would be appropriate and in accordance with the agenda of this Called Meeting. The Committee also considered the possibility that this legislation would be, to some degree, duplicating the intent of the bill which has been prepared by our Tallahassee staff and recommended by the Board of Governors.

"It was the opinion of this Committee that these two pieces of legislation, though not completely comparable, show some element of overlap in scope. It was the observation of the Committee that there are presently existing channels by which the Florida Medical Association's Committee on Legislation and Council on Legislation and Regulations can consider a stance regarding this bill; and if appropriate, offer the support of the Florida Medical Association to the endeavor of the Florida Association of County Health Officers.

"It was the opinion of the Committee and the Committee's interpretation of the sense of the audience that we are obviously in favor of clear lines of communication and responsibility in the health affairs of the government of the State of Florida; the question being only the method that might be chosen to secure better health services for the people of our State.

"The Committee feels after consideration and testimony that support of the legislative recommendations by the Board of Governors at the present time is the proper course of action for the legislation to pursue.

"Mr. Speaker, I move that Item No. 3, Legislation to Create a Separate Department of Health with Cabinet Rank, be adopted as a part of the Legislative Program of the Florida Medical Association for the 1977 session of the Florida Legislature."

An amendment to the motion was moved, to add a comma after the last word, "Legislature", and the words, "or as soon thereafter as possible", so that the motion would read: "Legislation to Create a Separate Department of Health with Cabinet Rank, be adopted as a part of the Legislative Program of the Florida Medical Association for the 1977 session

of the Florida Legislature, or as soon thereafter as possible."

The amendment carried, and the motion carried as amended.

"Mr. Speaker, the three items considered by your Committee were proposed to it by the Board of Governors in the priorities listed. It is the Committee's observation that with our excellent staff in Tallahassee, all three of these items will be supported diligently and skillfully. Realizing the need for priority, the Committee reaffirms the priorities suggested by the Board of Governors in its Recommendation No. 1."

Report of the BOARD OF GOVERNORS

Jack A. MacCris, M.D., Chairman

Recommendation No. 1

That the House of Delegates Adopt the following legislative program for the 1977 session of the Florida Legislature with priority as listed:

- 1. Enactment of an absolute two-year statute of limitations.**
- 2. Provision for recovery of defense costs in medical malpractice cases.**
- 3. Legislation to create a separate Department of Health with cabinet rank.**

"Mr. Speaker, the Committee in its consideration of the written and oral presentation heard by it, is greatly impressed by the interest of the membership of the Association and wishes to thank its members who attended its meeting and offered input into its deliberations. The Committee also observes with gratitude, the skill and effort which went into last year's legislative efforts and the preparation for the coming year by the staff of our Tallahassee office, and by the consultants and counsel with which they work. We wish to particularly express thanks to Mr. Scotty Fraser, Mr. George Palmer, Mr. John Thrasher, and Mr. John French and their staff who have performed in what we consider exemplary fashion over the past year. Their efforts were coordinated with the skills of Doctor John C. Kruse, Chairman of the Committee on State Legislation and Doctor James B. Perry, Chairman of the Council on Legislation and Regulations to whom we express our appreciation.

"Your Chairman wishes to thank the members of this Committee: Paul C. Harding, M.D., Victor H. Knight, Jr., M.D., Barney E. McRae, M.D. and David T. Overbey, M.D. for their patience with the Chairman and their efforts on behalf of the Association."



Reference Committee II is all happy faces, probably because its work has been completed. Left to right: Ms. Jan Taylor, Recording Secretary; Henry M. Yonge, M.D., Pensacola; Dick Van Eldik, M.D., Lake Worth; Vincent P. Corso, M.D., Miami, Chairman; O. Frank Agee, M.D., Gainesville; and Charles Hayes, M.D., Jacksonville.

"Mr. Speaker, I move the adoption of the report of Reference Committee No. I, as a whole, as amended."

The motion carried.

"Mr. Speaker, this concludes the report of Reference Committee No. I."

Report of Reference Committee No. II Miscellaneous Business

The Speaker, Dr. Kahn, assumed the Chair and called for the report of Reference Committee No. II, Miscellaneous Business.

Dr. Vincent P. Corso, Chairman, and his committee came forward to present the report of the Reference Committee.

Report of the Board of Governors Policy Statement Hospital Medical Staff Appointments Recommendation No. 2

Recommendation No. 2 was reviewed and the Committee felt that the first two paragraphs should be reversed and the following substitute recommendation is offered:

"The Florida Medical Association questions the advisability of a defensive requirement of some Florida Hospitals that each physician carry a specific amount of personal professional liability insurance as a prerequisite to hospital staff privileges and believes this to be an unnecessary requirement imposed on physicians.

"The FMA further reaffirms its belief that such a requirement for hospital privileges may actually encourage, rather than discourage the proliferation of unwarranted legal actions against both physicians and hospitals.

"The FMA is confident that such a requirement in no way insures quality care to the public but rather, may actually work to the disadvantage of the patient by imposing such financial constraints on some types of physicians so as to exclude them from hospital practice."

"It is the opinion of the FMA that the primary consideration for hospital medical staff appointments should be based on professional qualifications of the individual physician."

The motion to adopt substitute recommendation No. 2 carried.

FMA Position on Medicaid Recommendation No. 3

The Committee recommended the following substitution recommendation:

"The Florida Medical Association strongly supports the efforts of its membership who provide health care for the medically indigent through various mechanisms including the Medicaid Program.

"The FMA recognizes that there are still administrative and fiscal inadequacies in the Medicaid Program but also realizes there are some patients whose health needs will be funded by this means and recommends a broadening effort to supply quality health care within this mechanism.

"The FMA urges improvement in the Department of Health and Rehabilitative Services computer capability and data retrieval to achieve patient, physician, and institution profiles.

"If abuse of the Medicaid Program exists, whether by patient, physician, or institution, such abuse should be identified, investigated, and appropriate action initiated.

"When physician abuse is suspected, the FMA Peer Review Program should be utilized to review the problem."

The Chairman moved the adoption of the substitute recommendation No. 3.

A motion was made to change the substitute recommendation in the first paragraph by inserting the word "quality" after provide so that the first paragraph would read: "The Florida Medical Association support the efforts of its membership who provide quality health care for the medically indigent through various mechanisms including the Medicaid Program."

The Speaker announced that since the insertion of the word "quality" did not change either the sense or the intent of the first paragraph, the change would be accepted without a vote.

An amendment was to change the substitute recommendation, second paragraph, to read: "The FMA recognizes that there are many administrative and fiscal inadequacies in the Medicaid Program and also realizes there are some patients whose health needs are funded by this means and therefore recommends continued efforts to seek quality health care within a better mechanism."

The motion to amend carried.

The motion to adopt the Substitute Recommendation No. 3 carried as amended.

A motion to adopt the Report of the Board of Governors as amended carried.

Report of the BOARD OF GOVERNORS

Jack A. MaCriss, M.D., Chairman

Recommendation No. 2

That the House of Delegates adopt the following policy statement concerning hospital medical staff appointments:

"The Florida Medical Association questions the advisability of a defensive requirement of some Florida hospitals that each physician carry a specific amount of personal professional liability insurance as a prerequisite to hospital staff privileges and believes this to be an unnecessary requirement imposed on physicians.

"The FMA further reaffirms its belief that such a requirement for hospital privileges may actually encourage, rather than discourage the proliferation of unwarranted legal actions against both physicians and hospitals.

"The FMA is confident that such a requirement in no way insures quality care to the public but rather, may actually work to the disadvantage of the patient by imposing such financial constraints on some types of physicians so as to exclude them from hospital practice."

"It is the opinion of the FMA that the primary consideration for hospital medical staff appointment should be based on professional qualifications of the individual physician."



These FMA Council Chairmen reported on their official activities during a General Session that was conducted in conjunction with the Called Meeting of the House of Delegates. Left to right: J. Russell Forlaw, M.D., Boynton Beach, Council on Medical Services; James B. Perry, M.D., Ft. Lauderdale, Council on Legislation and Regulations; J. Lee Dockery, M.D., Gainesville, Council on Scientific Activities; and William W. Thompson, M.D., Ft. Walton Beach, Judicial Council. Others reporting were: James L. Borland Jr., M.D., Jacksonville, Council on Medical Systems; and James F. Richards Jr., M.D., Orlando, Council on Medical Economics.

FMA Position on Medicaid

The Board reviewed a report from Donald G. Nikolaus, M.D., Chairman of the Special Committee on Nursing Homes, regarding the Medicaid Program in Florida.

Medicaid expenses for 1975-76 was \$183 million, with a deficit carried forward of \$8 million.

The Medicaid budget for 1976-77 is \$219 million with an anticipated carry-forward deficit of \$15 million and includes:

In-patient hospital	27%	(\$59.6 million)
Out-patient hospital	3%	(\$ 7.3 million)
Nursing home care	36%	(\$78.1 million)
Drug Program	12%	(\$26.7 million)
Physicians' services only	8%	(\$18.1 million)
Out-patient laboratory and x-ray services	less than 1%	(\$ 1 million)

Safeguards included in the Florida Medicaid system hold abuses found in other states to a minimum:

1. No reimbursement for laboratory work or x-rays done in the physician's office
2. Limit of \$50 per year on laboratory or x-ray services as an out-patient not in a hospital
3. Maximum payment of \$20 per month per individual for prescribed medication
4. 45 days hospitalization per person per year
5. \$100 limit per year on out-patient hospital services

Recommendation No. 3

That the House of Delegates adopt the following position on Medicaid:

"The Florida Medical Association strongly supports the efforts of its membership who provide quality health care for the medically indigent through various mechanisms including the Medicaid Program.

"The FMA recognizes that there are many administrative and fiscal inadequacies in the Medicaid Program and also realizes there are some patients whose health needs are funded by this means and therefore recommends continued efforts to seek quality health care within a better mechanism."

"The FMA urges improvement in the Department of Health and Rehabilitative Services computer capability and data retrieval to achieve patient, physician, and institution profiles.

"If abuse of the Medicaid Program exists, whether by patient, physician, or institution, such abuse should be identified, investigated, and appropriate action initiated.

"When physician abuse is suspected, the FMA Peer Review Program should be utilized to review the problem."

Resolution 77-CM-1 Professional Liability Orange County Medical Society

The motion to adopt Resolution 77-CM-1, Professional Liability, as presented, carried.

Resolution 77-CM-1 Professional Liability

RESOLVED, That the policy of the Florida Medical Association shall be to oppose any form of mandatory insurance or financial obligation relating to professional liability.

"Mr. Speaker, I move the adoption of the report of Reference Committee No. II as a whole as amended."

The motion carried.

The Chairman thanked the members of the committee, Doctors O. Frank Agee, Charles P. Hayes, Dick L. Van Eldik, and Henry M. Yonge; those members of the Florida Medical Association who participated in the discussions, and Mr. John B. Richardson and the secretary, Ms. Jan Taylor, for their assistance.

"Mr. Speaker, this completes the report of Reference Committee No. II."

The Speaker announced that at the request of the President, the House would now go into Executive Session and excused all guests from the meeting. The Executive Vice President, W. Harold Parham, D.H.A., and the Executive Director, Mr. Donald C. Jones, were invited to remain.

HOUSE OF DELEGATES EXECUTIVE SESSION

The Speaker turned the podium over to Dr. MaCris, FMA President, for a special report.

Dr. MaCris explained that the purpose for the Executive Session was to discuss confidential aspects of certain FMA programs. The Executive Session would enable the House to discuss these subjects freely and with complete candor.

Dr. MaCris made an indepth presentation to the House, including the use of slides, regarding the FMA Insurance Programs; FMA Professional Liability Insurance Trust, Florida Physicians' Insurance Reciprocal and the Professional

Insurance Management Company. He outlined the background which led to the establishment of Harlan-Med, Inc. the FMA-PLI-TRUST in January of 1975, and subsequently the implementation of the Florida Physicians' Insurance Reciprocal on January 1, 1977. There was a complete explanation regarding the finances of all four of these organizations including the organizational structure, stockholders, individual compensations, and the responsibilities of the Executive Vice President in representing the Association in the management of these corporations on behalf of the FMA.

Following this presentation there was a general discussion and answer period with members of the House regarding the mechanics of operating the program. The House of Delegates expressed its appreciation and commendations with a standing ovation for the FMA Officers, Dr. Walker, Dr. Parham and others who have contributed their time and efforts in establishing these companies and programs.

There being no further business of the House, the benediction was given by Dr. Donald G. Nikolaus of Dunedin and the House of Delegates was adjourned.

Program Approval Procedure Change Voted by Committee on CME

The Committee on Continuing Medical Education has made significant changes in its procedures for reviewing locally-planned educational activities for FMA Mandatory Credit.

Effective immediately, program sponsors will no longer be required to submit their programs and applications for approval at least 30 days in advance, according to Yank D. Coble Jr., M.D., of Jacksonville, Chairman of the Committee. The Committee will review any application provided it is received before the program takes place; however, no retroactive approval will be granted.

As before, applicants submitting programs to the FMA at least 30 days prior to the offering will be notified of approval in time to include a credit note in the printed program or to announce credit at the meeting.

Meeting in Tampa on January 7, the Committee also decided to involve county medical society CME chairmen in the review and approval procedure as soon as details are worked out. Under the present system, the complete review process has been accomplished through the Committee's Subcommittee on Program Approval. The change

will authorize the local CME chairman to evaluate and make appropriate recommendations to the State committee regarding planned programs in his area.

In other actions of importance, the Committee:

—Voted to accept certification or recertification by the American Board of Internal Medicine, in medicine or a subspecialty, as complete fulfillment of the individual CME requirement for the three year cycle in which certification is granted. The Committee will consider similar acceptance for other specialties if a documented request is filed by the FMA recognized organizations representing those specialties in Florida (i.e., Florida Orthopedic Society for the American Board of Orthopedic Surgery, etc.).

—Recommended to the American Medical Association Council on Medical Education that the CME programs of the Dade County Medical Association and the Florida Academy of Family Physicians be accredited provisionally for one year beginning January 7, 1977. This would allow them to sponsor or co-sponsor educational activities for category 1 credits.

Toll-Free Number for Neonatal Intensive Care

Children's Medical Services has announced the initiation of a statewide toll-free line serving its network of seven Regional Intensive Care Centers. By calling 1-800-282-2735, any physician in Florida can quickly determine **if** and **where** a bed is available for a newborn infant requiring neonatal intensive care. The regional centers operate at maximum bed census, thus beds are not always available. This telephone service will not guarantee a bed, but will alleviate the difficulty of locating one.

Many groups and individuals cooperated with Children's Medical Services in planning and implementing this project. The Florida Perinatal Intensive Care Program was responsible for initial planning. Tampa General Hospital has provided invaluable administrative support. Dr. Howard B. Harris, a Tampa Neonatologist developed the operational plan and provided the professional input. Financial support came from Children's Medical Services and from generous donations by the Florida Affiliate of the American Heart Association, by the Broward County Affiliate of the American Heart Association, and by the Friends of Children, Inc.

A mailout to acquaint nurseries and those physicians dealing with newborns with the details of this project is forthcoming from the Children's Medical Services Program Office. Information is also available through the toll-free line.

Julia R. St. Petery, M.D. is Staff Director of the Children's Medical Services Program Office, Department of Health and Rehabilitative Services, Tallahassee.

PMUR's Benefits

The Florida Medical Association's Board of Governors requested the Florida Medical Foundation to start Peer Medical Utilization Review (PMUR) because of the Bureau of Health Insurance's concern with utilization of the Medicare program in Florida. The state has many residents over age 65. PMUR began functioning in 1970.

The PMUR Committee's primary concern is to insure that the amount of utilization is consistent with quality medical care. Secondarily, it seeks to contain the escalating costs of that care. Understandably, the Bureau might be more interested in the latter objective. Members of the Committee are engaged in the various specialties; they practice in many areas of the state.

Each component county medical society was requested to establish a PMUR committee which would be responsible for basic local review. The response has been good. Some societies are doing outstanding work, most good, and a very few could cooperate better.

The state PMUR Committee met four times during 1976, once with representatives of Blue Shield and Group Health Insurance to assure smooth transition of Dade and Monroe Counties PMUR activities. Group Health Insurance became fiscal agent for these areas on July 1, 1975.

Just as in determining true quality, it is difficult to give exact results of the Committee's effectiveness in raising the level of quality care. In numerous instances continuing education has been pursued and utilization definitely reduced. The county medical societies and FMA Judicial Council have conducted investigations of possible deficiencies.

Cost and effectiveness of the peer review process have been determined by staff members of Georgia Tech and the University of Kentucky in a study commissioned by the Bureau of Health Insurance. The study has other benefits - recoverable over payments, and deterrent against over utilization by physicians due to peer review. The study group reports that benefits of peer review outweighs cost about eight to one due to good cooperation by Florida Medical Association members. Over a four year period (1971 - 1974) they estimate that the deterring effect of peer review upon over utilization approximated \$4 million.

Burns A. Dobbins, M.D., Vice Chairman
Florida Medical Foundation's Committee
on PMUR

State Medical Journal Editors Hear Encouraging News

The almighty computer, long a nemesis of state medical journals, may be losing ground to human judgment, at least in one area.

This was welcome news to journal editors and business managers attending a conference sponsored by the State Medical Journal Advertising Bureau conference in Chicago on January 20.

Conference participants remembered the "good old days" when human decisions were the principal factor in determining how the drug industry's advertising dollar was parceled out. State journals had favored status.

Enter the computer. The cold, hard figures it churned out told advertisers and their agencies they'd better put their money in the specialty journals, and popular throwaways. Thus, these got fatter and the state journals got thinner.

Now, the pendulum is swinging back to subjective decisions in advertising purchases, according to Ms. Betti Barrows, a representative of Sieber & McIntyre, Inc., an advertising agency. And, she said, state journals offer drug advertisers many pluses, including the opportunity to advertise

products on a regional basis, and to support national advertising promotions.

Another speaker, Mr. John Gisler of The Upjohn Company, said that physician involvement with his state medical journal is more impressive to his company than the advertising rate structure. He suggested that state journals can make themselves distinctive and popular with advertisers by capitalizing on continuing medical education.

A somewhat dimmer view was taken by Mr. Jim Russo of the Pharmaceutical Manufacturers Association. He said the economic health of many firms is poor because of rising costs, smaller profits, problems with the bureaucracy of the Food and Drug Administration in approving new products, generic drug laws and other factors.

Drug firms are cutting their advertising budgets, and because of generic substitution laws, more advertising funds are being diverted from medical journals to pharmaceutical journals.

Gerold L. Schiebler, M.D., Editor of **The Journal of the Florida Medical Association**, attended the conference.

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You can help fight heart diseases that will kill one million Americans this year.

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5th AMA National Leadership Conference Draws 600 M.D.'s and Executives

Working to achieve a unified federation and sharing practical information on major issues, more than 600 physicians and medical society executives in January participated in the fifth AMA National Leadership Conference.

AMA President Richard E. Palmer, M.D., pointed out that the federation is "the only place where all physicians can come together as one," not only to counter threats to the profession but to carry out the profession's obligations to society; and New Jersey delegate James S. Todd, M.D., called for an end to the "pass-the-buck phenomenon" at all levels of medicine and for renewed mutual efforts to solve the problems that affect the entire profession and the public.

In these efforts the federation will have the public's confidence. George Gallup Jr., president of the Gallup Poll, told the conference that the image of physicians and the AMA is "extremely high." The public rates physicians at the top of 11 occupational groups in honesty and ethical standards, he said, and the AMA ranks high in credibility. Seventy-one percent of the public, Gallup reported, has a great deal or fair amount of trust in medical organizations to propose a fair and workable national health insurance program. Only 49% have such confidence in federal health officials, and only 47% have this amount of trust in labor unions.

Another call for cooperative effort came from Sen. Herman E. Talmadge (D-Ga.), who said friction between governmental payers and physicians is "here to stay." The task for both Congress and physicians, he said, is to develop constructive solutions by dealing "candidly, cooperatively and open-mindedly with each other." Talmadge predicted that his amendments to curb Medicare-Medicaid fraud and abuse will pass early in this session of Congress. He said he would introduce his Medicare-Medicaid Administrative and Reimbursement Reform bill, a controversial proposal that got stalled in the last Congress, after he has consulted with the Carter Administration.

On national health insurance Talmadge, who said he opposed federalization that "would make this country into another Great Britain," noted that President Carter's stated intention to phase-in any NHI program indicates that "there is great room for agreement between that gradual approach and the incremental approach outlined in the Long-Ribicoff-Talmadge bill" for catastrophic health insurance. Another conference speaker, syndicated columnist George F. Will, said there is "broad bipartisan support in Congress for catastrophic health insurance." Will also said there would be another attempt by Congress to alter the distribution of physicians, either by coercion or incentive. Two members of Congress, Sen. Thomas F. Eagleton (D-Mo.) and Rep. John M. Murphy (R-N.Y.), told another conference panel that federal financial problems have slowed the momentum toward NHI. Costs alone are enough to stop a Kennedy-Corman type bill, Eagleton said, especially since Congress is already concerned about the actuarial soundness of Social Security.

A first-hand analysis of the British National Health Service was provided at the conference by two British physicians and a NHS district administrator. While describing what they considered to be the good points of the British system and the electorate's satisfaction with it, all gave warnings about political control, bureaucracy, standardization, and "the master plan." Said the NHS administrator, Robin Anson-Owen: "Your new Administration cannot be so crass as to make the same mistakes as we have . . . can surely see that the greater good, both for the patient, the profession and the government itself will come from leaving the profession free from restraint . . . Do not be misled by the overtures of the government; fight against the elimination of the insurance mechanism, oppose the contracting of physicians to government, and above all resist having your physicians in the employ of government."



The Journal Visits AMA Leadership Conference

Upper left: Thomas O. Brackett, M.D., Winter Haven. Upper right: Mr. William Coletti of St. Petersburg, Executive Director of the Pinellas County Medical Society, chats with FMA President-Elect Louis C. Murray, M.D., Orlando. Middle right: Enjoying lunch are FMA President Jack A. MacCris, M.D., St. Petersburg; Archie T. Johnson, M.D., Assistant Secretary of Health, State of North Carolina, Raleigh; Gerold L. Schiebler, M.D., Gainesville, Editor of THE JOURNAL; Thomas O. Brackett, M.D., Winter Haven; Louis C. Murray, M.D., Orlando; and Mr. Donald C. Jones, Jacksonville, FMA Executive Director. Right picture, third from top: FMA President Jack A. MacCris, M.D. AMA House Speaker Thomas E. Nesbitt, M.D., Nashville, Tenn., and Jere W. Annis, M.D., Lakeland, Vice Chairman of the AMA Board of Trustees.

Left picture: Mr. Donald C. Jones, Jacksonville, FMA Executive Director; Jere W. Annis, M.D., Lakeland, Vice Chairman of the AMA Board of Trustees; and Mr. Michael Lopez, West Palm Beach, Executive Vice President, Palm Beach County Medical Society. Right: Mrs. Charles H. Gilliland, Gainesville; and Mrs. John W. Glotfelty, Lakeland.

Left picture: Archie T. Johnson, M.D., Raleigh, N.C., and Gerold L. Schiebler, M.D., Gainesville. Right picture: Dr. and Mrs. Jere W. Annis, Lakeland.

Journal photos by John W. Glotfelty, M.D., Lakeland

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W. HAROLD PARHAM, D.H.A., EXEC. VICE PRES. / DONALD C. JONES, EXEC. DIRECTOR / CAROLYN K. KENYON, EDITOR

March 2, 1977

No. 77-3

Professional Liability Insurance Crisis

THE PROFESSIONAL LIABILITY LEGISLATION SPONSORED BY THE FMA AND ADOPTED BY THE 1976 SESSION OF THE FLORIDA LEGISLATURE WAS DECLARED UNCONSTITUTIONAL by a Second Judicial Circuit Court, in and for Leon County, Florida, on February 28, 1977.

This Law included provisions for:

1. Structured pay-out of future damages (The Senate-House Conference Committee amended this provision for structured pay-outs only when damages exceed \$200,000).
2. Definition of medical professional negligence.
3. Application of collateral sources in jury trials, as a direct offset.
4. Definition of medical expert witnesses.
5. Prohibit use of res ipsa loquitur doctrine in professional negligence actions.
6. A Remittitur-Additur provision which provides for the judge to lower or raise an award if, in his opinion, the jury verdict is excessive or inadequate.

THIS DEVASTATING DECISION BY THE LOWER COURT WILL BE APPEALED BY THE FMA TO THE FLORIDA STATE SUPREME COURT AT THE EARLIEST POSSIBLE DATE.

THE FMA SPONSORED PROFESSIONAL LIABILITY LEGISLATIVE PROGRAM FOR THE 1977 SESSION WILL ENCOMPASS ALL OF THE PROVISIONS WHICH HAVE BEEN STRICKEN BY THE COURT (unless these provisions are restored by the State Supreme Court) AND WILL INCLUDE THESE FMA RECOMMENDATIONS FOR THE 1977 SESSION:

1. An absolute two-year statute of limitations
2. Recovery of defense cost

EVERY MEMBER OF THE FMA WILL BE ADVISED AT AN EARLY DATE REGARDING THE OUTCOME OF THE APPEAL TO THE STATE SUPREME COURT AND THE COMPLETE, FINALIZED LEGISLATIVE PROGRAM OF YOUR ASSOCIATION FOR THE 1977 SESSION.

The Court in this decision also declared unconstitutional provisions of the law dealing with:

1. Hospital Internal Risk Management Programs
2. Medical Incident Committee reports
3. Actions by Medical Incident Committees
4. Revisions of the Patient's Compensation Fund which:
 - a. Limits payment of awards to \$100,000 to one individual in any calendar year.
 - b. Physicians participating in the Patient's Compensation Fund cannot be assessed more than one additional annual premium in any year.
5. The section of the law dealing with the Unfair Insurance Trade Practices Act (which was attached to our legislation and raised serious constitutional questions).

THE FMA SPONSORED LEGISLATION ADOPTED BY THE 1975 SESSION OF THE FLORIDA LEGISLATURE WAS NOT AFFECTED BY THIS DECISION.

These provisions of the law are:

1. Pretrial Mediation Panels
2. 2-2&4 Statute of Limitations (two years from the date of incident or the date of discovery but in no event to exceed four years).

Annual Meeting Scientific Program Offers Something for Everyone

Except for a few last minute details, planning is virtually complete for the scientific program of the 103rd Annual Meeting of the Florida Medical Association.

The sessions, running from Wednesday, May 4, to Saturday, May 7, at Bal Harbour's Americana Hotel, will offer something of interest to just about everyone, including the FMA Auxiliary.

A special scientific program for the Auxiliary, entitled "Cardiovascular Disease for the Doctor's Wife," will be held on Friday afternoon, May 6, under the sponsorship of the Committee on Continuing Medical Education.

In addition, members of the Auxiliary may sign up for either of two sessions of the Section on Basic Life Support Certification. Co-sponsored by the Florida Chapter of the American College of Emergency Physicians, the program will be held Friday morning, beginning at 8:00 a.m., and will be repeated that afternoon at 2:00 p.m.

The scientific program will get under way on Wednesday afternoon, May 4, with a Symposium on the Medical and Surgical Approaches to Stroke, also sponsored by the CME Committee.

Department of Family Practice, Medical University of South Carolina, Charleston.

Four hours of "Dialogue" will be presented, two on Friday morning and two Friday afternoon. Each segment will feature a guest speaker, who will give a brief overview of a topic of current interest and answer audience questions for the remainder of the hour.

"Dialogue" is presented through the courtesy of Pfizer Laboratories and Roerig Divisions of Pfizer Pharmaceuticals.

Wyeth Laboratories will once again provide programmed instruction on a number of clinical subjects with the aid of teaching machines called AutoTutors. Generally, these will be available for use during the scientific program hours Thursday, Friday and Saturday.



Hiram B. Curry, M.D.

The program has been designated for 20 hours of FMA Mandatory and AMA Category 1 credit. In addition application has been made to the Florida Academy of Family Physicians for approval of Prescribed Credit for the Section on Family Practice, the Section on Nuclear Medicine and Family Practice, the four "Dialogue" hours, and Programmed Instruction with the AutoTutor.

WEDNESDAY AFTERNOON—MAY 4

SYMPOSIUM ON THE MEDICAL AND SURGICAL APPROACHES TO STROKE

(Sponsored by FMA Committee on Continuing Medical Education)

Wednesday—1:00 p.m. to 2:30 p.m.

Michael J. Pickering, M.D., Tampa

Daniel B. Nunn, M.D., Jacksonville

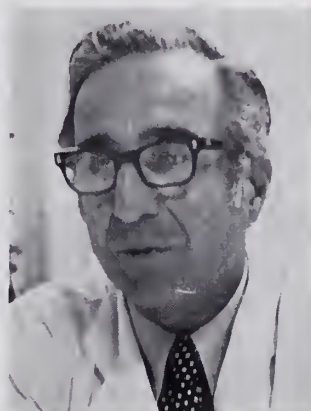
Program Co-Chairmen

Opening Remarks—Daniel B. Nunn, M.D., Jacksonville
"Surgical Approach to Stroke," Jesse E. Thompson, M.D., Professor of Surgery, University of Texas Southwestern Medical School, Dallas, Texas

"Medical Approach to Stroke," Pertiz Scheinberg, M.D., Professor and Chairman, Department of Neurology, University of Miami School of Medicine, Miami



Jesse E. Thompson, M.D.



Pertiz Scheinberg, M.D.

Guest speakers will be Jesse E. Thompson, M.D., Professor of Surgery, University of Texas Southwestern Medical School, Dallas; Pertiz Scheinberg, M.D., Professor and Chairman, Department of Neurology, University of Miami School of Medicine; and Hiram B. Curry, M.D., Professor and Chairman,

"General Practice Approach to Stroke," Hiram B. Curry, M.D., Associate Professor of Neurology and Professor and Chairman, Department of Family Practice, and Director, Residency Training Program in Family Practice, Medical University of South Carolina, Charleston, S.C.

Questions and Answers

Adjournment

SECTION ON INTERNAL MEDICINE

(Co-sponsored by American College of Physicians and Florida Society of Internal Medicine)

Wednesday—2:45 p.m. to 4:15 p.m.

Michael J. Pickering, M.D., Tampa
Program Chairman

"Use and Abuse of Antibiotics"

Opening Remarks—Charles P. Craig, M.D., Associate Professor of Medicine, University of South Florida College of Medicine, Tampa

"Limitations of Newer Antibiotics," Herbert L. DuPont, M.D., Professor of Medicine, University of Texas Medical School at Houston

"Adverse Effects of Antibiotics," Harold Neu, M.D., Professor of Medicine, Columbia University College of Physicians and Surgeons, New York

"Preventive Antibiotics," Calvin M. Kunin, M.D., Professor of Medicine, University of Wisconsin Medical School, Madison

Questions and Answers

Adjournment

THURSDAY AFTERNOON—MAY 5

SECTION ON NEUROLOGY

(Co-sponsored by Florida Society of Neurology)

Thursday—1:30 p.m. to 5:30 p.m.

Manuel J. Mier, M.D., Venice
Program Chairman

"Electromyography," Joel Brumlik, M.D., Professor and Chairman, Department of Neurology, Loyola University Stritch School of Medicine, Maywood, Ill.

"Computer Assisted Tomography (CT)," Jerome J. Sheldon, M.D., Chief of Neuro-Radiology, Mt. Sinai Medical Center, Miami Beach, and Professor of Radiology, University of Miami School of Medicine, Miami

"Electronic Implants," Ross Davis, M.D., Chief of Neurological Surgery, Mt. Sinai Hospital Medical Center, Miami Beach

"Echoencephalography," Manuel J. Mier, M.D., Director of the Neurology Laboratory, Venice Hospital, Venice

Adjournment

SECTION ON PSYCHIATRY

(Co-sponsored by Florida Council of District Branches of the American Psychiatric Association)

Thursday—1:30 p.m. to 4:20 p.m.

Samuel I. Greenberg, M.D., Miami
Program Chairman

"Current Drug Usage in Psychiatric Practice"

"Treatment of Target Symptoms," Edward H. Georgia, M.D., Chairman, Department of Psychiatry, St. Francis Hospital, Miami Beach

"Long-acting Thienothiazines," Joel Grossman, M.D., and Jaime Fontane, M.D., Clinical Instructors in Psychiatry, University of Miami School of Medicine, Miami

"Lithium Carbonate: Recent Findings," James J. Goodman, M.D., Assistant Professor of Psychiatry, University of Miami School of Medicine, Miami

"Drug Usage in Child Psychiatry," Warren W. Schlanger, M.D., Clinical Assistant Professor of Psychiatry, University of Miami School of Medicine, Miami

"Treatment of Affective Disorders," William L. Gustafson, M.D., Clinical Assistant Professor of Psychiatry, University of Miami School of Medicine, Miami

Open Discussion (Entire Panel)

Adjournment

SECTION ON FAMILY PRACTICE

(Co-sponsored by Florida Academy of Family Physicians)

Thursday—1:30 p.m. to 5:30 p.m.

D. Robert Howard, M.D., Tampa
Program Chairman

Objectives of the Section—D. Robert Howard, M.D., Professor and Chairman, Department of Family Medicine, University of South Florida College of Medicine, Tampa

"Current Concepts of Office Gynecology," James M. Ingram, M.D., Professor and Chairman, Department of Obstetrics and Gynecology, University of South Florida College of Medicine, Tampa

Questions and Answers

"Learning Disabilities in Children," Richard F. Kaine, M.D., Ft. Pierce

Questions and Answers

Coffee Break

"Panorama of Drug Interactions," George E. Crevar, Ph.D., Regional Medical Director, Smith Kline & French Laboratories, Atlanta, Ga.

Questions and Answers

"Human Sexuality in Family Practice—1977," David W. Epley, Ph.D., Clinical Assistant Professor, Alice MacMahan, R.N., Director, Parent Education, and Orris O. Rollie, M.D., Clinical Associate Professor, Family Practice Residency Program, Florida Hospital, Orlando

Questions and Answers

Adjournment

SECTION ON RHEUMATOLOGY

(Co-sponsored by Florida Society of Rheumatology)

Thursday—1:30 p.m. to 5:00 p.m.

Richard Panush, M.D., Gainesville
Program Chairman

"Gout and Pseudogout," John Talbott, M.D., Clinical Professor of Medicine, University of Miami School of Medicine,

and Editor, **Seminars in Arthritis and Rheumatism**, Miami

Questions and Answers

"A New Home Management System for Arthritic Patients," Gerald H. Stein, M.D., Assistant Professor of Medicine and Community Medicine, University of Florida College of Medicine, Gainesville

Questions and Answers

"Non-Articular Rheumatism," Charles M. Plotz, M.D., Med. Sc.D., Professor of Medicine, Downstate Medical Center, Brooklyn, N. Y.

Questions and Answers

Break

"Spondyloarthritis and HLA-B27," Selden Longley, M.D., Assistant Professor of Medicine, University of Florida College of Medicine, Gainesville

Questions and Answers

"Outpatient Management of Rheumatoid Arthritis," Bernard F. Germaine, M.D., Chief, Rheumatology Division, University of South Florida College of Medicine, Tampa

Questions and Answers

Panel Discussion (all speakers)

Adjournment

SECTION ON CHEST MEDICINE

(Co-sponsored by Florida Chapter, American College of Chest Physicians and Florida Thoracic Society)

Thursday—2:00 p.m. to 5:00 p.m.

Roberto Llamas, M.D., Miami Beach

Gerald Olsen, M.D., Jacksonville

Program Co-Chairmen

"Recent Advances in Lung Cancer"

Moderator: Wilbur Avery, M.D., Chief, Pulmonary Diseases, South Miami Hospital, South Miami

"Work-up, Indications for Surgery Results," Thomas B. Ferguson, M.D., Clinical Professor of Cardiothoracic Surgery, Washington University School of Medicine, St. Louis, Mo.

"Pre-operative Functional Evaluation," Gerald Olsen, M.D., Medical Director of Pulmonary Medicine, St. Vincent's Medical Center, Jacksonville

"Early Diagnosis," David Solomon, M.D., Staff Physician and Assistant Professor of Medicine, Pulmonary Diseases Section, Department of Internal Medicine, University of South Florida College of Medicine and Tampa Veterans Administration Hospital, Tampa

"Radiology," Luis Martinez, M.D., Associate Director of Radiology, Mt. Sinai Medical Center, Miami Beach, and Professor of Radiology, University of Miami School of Medicine, Miami

"Drug Regimens, Immunotherapy, New Developments," Oleg Selawry, M.D., Chief, Division of Lung Cancer, and Professor, Department of Oncology, Comprehensive Cancer Center, University of Miami School of Medicine, Miami

Adjournment

FRIDAY MORNING—MAY 6

SECTION ON BASIC LIFE SUPPORT CERTIFICATION

(Co-sponsored by Florida Chapter, American College of Emergency Physicians in Cooperation with the Heart Association of Greater Miami)

Friday—8:00 a.m. to 10:45 a.m.

Basic life support is an emergency first aid procedure that consists of the recognition of respiratory and cardiac arrest and starting the proper application of cardiopulmonary resuscitation to maintain life until a victim recovers sufficiently to be transported or until advanced life support is available.

The 1976 FMA House of Delegates encouraged all Florida physicians to become certified in basic life support.

Participants may register for either of two sessions:

Friday morning, May 6—8:00 to 10:45 a.m.

Friday afternoon, May 6—2:00 to 5:00 p.m.

This course is open to spouses and other family of FMA members. A registrant who successfully completes one of the sessions will receive certification in basic life support from the American Heart Association.

This course is practical in nature and registrants should be prepared to participate actively. A demonstration of practical skills is a prerequisite for successful course completion and certification.

SECTION ON NEONATAL-PERINATOLOGY

(Co-sponsored by Florida Chapter, American Academy of Pediatrics, Florida Pediatric Society, and Florida Society of Neonatal-Perinatologists)

Friday—8:00 a.m. to 10:45 a.m.

Charles Bauer, M.D., Miami

James A. Hallock, M.D., Tampa

Program Co-Chairmen

"Regionalization of Perinatal Care"

Introduction and Welcome—Charles Bauer, M.D., President, Florida Society of Neonatal-Perinatologists, Miami

"The Goals of Perinatal Regionalization," Allan G. W. McLeod, M.D., Professor of Obstetrics and Gynecology, University of Miami School of Medicine, Miami

"Outreach Educational Programs," Donald V. Eitzman, M.D., Professor of Pediatrics, University of Florida College of Medicine, Gainesville

"Interaction Between the Various Levels of Perinatal Care," Charles Bauer, M.D., Assistant Professor of Pediatrics, University of Miami School of Medicine, and President, Florida Society of Neonatal Perinatologists, Miami

Questions and Answers—Drs. McLeod, Eitzman and Monkus

Coffee Break

"Transportation and Communication Needs Within a Regionalized Program," Howard Harris, M.D., Assistant Professor of Pediatrics, University of South Florida College of Medicine, Tampa

"Long-Term Evaluation in the Perinatal Program," Edmund A. Egan, II, M.D., Assistant Professor of Pediatrics, University of Florida College of Medicine, Gainesville

"Future of the Perinatal Program—Legislative Action," Julia C. R. St. Petery, M.D., Director, Office of Children's Medical Services, Department of Health and Rehabilitative Services, Tallahassee

Questions and Answers—Drs. Harris, Egan and St. Petery

Adjournment

SECTION ON NUCLEAR MEDICINE AND
FAMILY PRACTICE

(Co-sponsored by Florida Association of Nuclear Physicians
and Florida Academy of Family Physicians)

Friday—8:00 a.m. to 10:45 a.m.
Aldo N. Serafini, M.D., Miami Beach
D. Robert Howard, M.D., Tampa
Program Co-Chairmen

"Noninvasive Diagnostic Techniques in Clinical Practice
For The Family Physician"

Welcome and Opening Remarks

"The Evaluation of the Jaundiced Patient—The Role of
Abdominal Ultrasound," Noel Zusmer, M.D., Assistant Pro-
fessor of Radiology, University of Miami School of Medicine
and Mt. Sinai Medical Center, Miami Beach

"Tumor Detection and Staging with Radioisotopes," Law-
rence R. Muroff, M.D., Clinical Assistant Professor of Radi-
ology, University of South Florida College of Medicine, Tampa

"Modern Therapeutic Trends in Oncology," Michael Troner,
M.D., Assistant Professor of Medicine, Division of Oncology,
University of Miami School of Medicine and Veterans Ad-
ministration Hospital, Miami

"Nuclear Cardiology," Aldo N. Serafini, M.D., Assistant Pro-
fessor of Radiology and Assistant Director, Division of
Nuclear Medicine, University of Miami School of Medicine,
Miami

"Pulmonary Embolism and Deep Vein Thrombosis—Detec-
tion and Treatment," Edward A. Eikman, M.D., Assistant
Professor of Medicine, University of South Florida College
of Medicine, and Chief, Nuclear Medicine Service, Veterans
Administration Hospital, Tampa

Questions and Answers

Adjournment

DIALOGUE

(Presented through the Courtesy of Pfizer
Laboratories and Roerig Divisions of
Pfizer Pharmaceuticals)
Friday—8:30 a.m. to 10:45 a.m.

Each one-hour segment of Dialogue will begin with a
five- or ten-minute overview of a topic of current interest
by a guest speaker. The remainder of each hour will include
audience questions.

"Hypertension," Barry Materson, M.D., Associate Professor
of Medicine, University of Miami School of Medicine, Miami

Recess

"Infections in General Surgery," Jesse Meredith, M.D., Pro-
fessor of Surgery, Bowman Gray School of Medicine of
Wake Forest College, Winston-Salem, N.C.

Adjournment

FRIDAY AFTERNOON—MAY 6

SECTION ON ORTHOPEDIC SURGERY
(SECTION I)

(Co-sponsored by Florida Orthopedic Society)

Friday—1:30 p.m. to 5:15 p.m.
Richard G. Onkey, M.D., Naples
Program Chairman

"Peroneal Compartment Syndrome in Athletes," Thomas
Haney, M.D., Tallahassee

"Preservation of Tissue in Fingertip Injuries," Merlin G.
Anderson, M.D., Assistant Professor of Surgery, University
of South Florida College of Medicine, Tampa

Discussion

"University of Miami Interpretation of the Double Blind
Study of Chymopapain," Mark D. Brown, M.D., Assistant
Professor of Orthopedic Surgery, University of Miami School
of Medicine, Miami

Discussion

"Anterior Cervical Fusion—Clinical Experience," A. Clarke
Miller, M.D., Sarasota

Discussion

"Total Knee Replacement—Evolution of Design," Roderick
H. Turner, M.D., Massachusetts General Hospital, Boston,
Mass.

Discussion

"Use of the Functional Status Examination in Rehabilita-
tion," Howard Hogshead, M.D., Clinical Associate Professor
of Orthopedic Surgery, University of Florida College of
Medicine (JHEP), Jacksonville

Discussion

"Infections of the Hand," Ronald J. Mann, M.D., Assistant
Professor of Orthopedic Surgery, University of Miami School
of Medicine, Miami

Discussion

"An Unusual Presentation of Osteomyelitis," William A.
Stolzer, M.D., Ft. Pierce

Discussion

"Autologous Blood Transfusion and Total Joint Replacement
Surgery," James L. Cain, M.D., Vero Beach

Discussion

Adjournment

SECTION ON PREVENTIVE MEDICINE

(Co-sponsored by Florida Society for Preventive Medicine)
Friday—1:30 p.m. to 5:00 p.m.

James T. Howell, M.D., Palm Springs
Program Chairman

"Influenza—Past, Present and Future," E. Charlton Prather,
M.D., M.P.H., Director, Health Program Office, Department
of Health and Rehabilitative Services, Tallahassee

"Current Communicable Disease Problems at the Center
for Disease Control and Update on Smallpox Eradication,"
Stanley Music, M.D., Center for Disease Control, Atlanta, Ga.

Break

"Modern Tuberculosis Treatment," Clifford Cole, M.D.,
Director of Community Tuberculosis Program Services, De-

partment of Health and Rehabilitative Services, Jacksonville

"Current Cardiovascular Risk Factor Reversal Programs and Update on the Mr. Fit Program," George Christakis, M.D., M.P.H., Professor of Public Health and Epidemiology, University of Miami School of Medicine, Miami

Questions and Answers

Adjournment

SECTION ON COLON AND RECTAL SURGERY

(Co-sponsored by Florida Society of Colon and Rectal Surgeons)

Friday—1:30 p.m. to 5:00 p.m.

Manuel Carbonell, M.D., Miami

Program Chairman

"Changing Concepts of Colo-Rectal Cancer," Malcolm C. Veidenheimer, M.D., Chairman, Section of Colon and Rectal Surgery, Lahey Clinic Foundation, and Lecturer in Surgery, Harvard Medical School, Boston, Mass.

"The Use of Local Anesthesia in Ano-Rectal Surgery," Frederick E. Farrer, M.D., Miami

"Unusual Manifestations of Endometriosis," Carlos Alvarez, M.D., San Salvador; and Manuel Carbonell, M.D., Clinical Instructor in Surgery, University of Miami School of Medicine, Miami

"Supra Levator Fistula—The Iatrogenic One," Emmet F. Ferguson, M.D., Clinical Assistant Professor of Surgery, University of Florida College of Medicine (JHEP), Jacksonville

"Uncommon Colonoscopic Findings," John P. Christie, M.D., Miami

"Intraoperative Testing of Left Colon Anastomoses," Shed H. Roberson, M.D., Daytona Beach

Questions and Answers

Adjournment

DIALOGUE

(Presented through the Courtesy of Pfizer Laboratories and Roerig Divisions of Pfizer Pharmaceuticals)

Friday—2:00 p.m. to 4:15 p.m.

Each one-hour segment of Dialogue will begin with a five- or ten-minute overview of a topic of current interest by a guest speaker. The remainder of each hour will include audience questions.

"1977—Management of Asthma in Childhood," Heinz J. Wittig, M.D., Professor of Pediatrics and Chief of Allergy, Department of Pediatrics, University of Florida College of Medicine, Gainesville.

"Complications of Diabetes," Charles R. Shuman, M.D., Professor and Chief, Metabolic Service, Temple University Hospital, Philadelphia.

Recess

SECTION ON BASIC LIFE SUPPORT CERTIFICATION

(Co-sponsored by Florida Chapter, American College of Emergency Physicians in Cooperation with the Heart Association of Greater Miami)

Friday—2:00 p.m. to 5:00 p.m.

See program under "Friday Morning—May 6"

SECTION ON THORACIC AND CARDIOVASCULAR SURGERY

(Co-sponsored by Florida Society of Thoracic Surgeons)

Friday—2:00 p.m. to 4:00 p.m.

Daniel B. Nunn, M.D., Jacksonville

Program Chairman

"Physiologic and Surgical Considerations of the Coronary Circulation," David C. Sabiston, M.D., James B. Duke Professor and Chairman, Department of Surgery, Duke University School of Medicine, Durham, N.C.

"Medical and Surgical Treatment of Coronary Artery Disease" (Panel)

Moderator:

Daniel B. Nunn, M.D., Clinical Assistant Professor of Surgery, Division of Thoracic and Cardiovascular Surgery, University of Florida College of Medicine (JHEP), and Chief of Thoracic and Cardiovascular Surgery, Methodist Hospital, Jacksonville

Panelists:

Edward Spoto, Jr., M.D., Associate Professor of Medicine, University of South Florida College of Medicine, Tampa

Clifford R. Guy, M.D., Clinical Assistant Professor of Medicine, Division of Cardiology, University of Florida College of Medicine (JHEP), Jacksonville

Thomas O. Gentsch, M.D., Clinical Associate Professor of Thoracic and Cardiovascular Surgery, University of Miami School of Medicine, Miami

David C. Sabiston, M.D.

Adjournment

SECTION ON RADIOTHERAPY (SECTION I)

(Co-sponsored by Florida Radiological Society)

Friday—2:00 p.m. to 5:00 p.m.

Phillip C. Smith, M.D., Gainesville

Program Chairman

Opening Remarks and Welcome—Herbert D. Kerman, M.D., Chairman, Radiotherapy Section, Florida Radiological Society, Daytona Beach

"Curative Radiation for Unusual Tumors—Chemodectoma, Optic Glioma and Craniopharyngioma," Robert G. Parker, M.D., Immediate Past President, American Society of Therapeutic Radiologists, and Professor of Radiotherapy, University of Washington School of Medicine, Seattle, Wash.

Selected Papers to be Announced

Adjournment

SECTION ON RADIOLOGY

(SECTION I)

(Co-sponsored by Florida Radiological Society)

Friday—2:00 p.m. to 4:30 p.m.

Robert J. Mandel, M.D., Melbourne
Program Chairman

Welcome and Opening Remarks—Paul J. Popovich, M.D., President, Florida Radiological Society, Melbourne

"The Physics of CAT Scanning," Jerome Sheldon, M.D., Assistant Professor of Radiology, University of Miami School of Medicine, and Attending Radiologist, Mt. Sinai Hospital, Miami Beach

"CAT Equipment," O. Frank Agee, M.D., Professor of Radiology, University of Florida College of Medicine, Gainesville; and Juri Kaude, M.D., Professor of Radiology, University of Florida College of Medicine, Gainesville

"The Health System Agency and Radiology," Kim Beaton, Chairman, Regional Health System Agency, Orlando; and Jerry Conger, Office of Medical Services, Tallahassee

Adjournment

SECTION ON NEPHROLOGY

(Co-sponsored by Florida Society of Nephrology)

Friday—2:00 p.m. to 5:30 p.m.

Robert A. Metzger, M.D., Orlando
Program Chairman

A. Gorman Hill Memorial Lectureship—(Speaker to be Announced)

Symposium on When's and Why's of Renal Disease

"Renal Biopsy," Stephen I. Rifkin, M.D., Assistant Professor of Medicine, University of South Florida College of Medicine, Tampa

"Acute Renal Shutdown," J. Phillip Pennel, M.D., University of Miami School of Medicine, Miami

"Chronic Dialysis," William Way Anderson, M.D., South Florida Artificial Kidney Center, and Clinical Associate Professor of Medicine, University of Miami School of Medicine, Miami

"Renal Transplantation," William W. Pfaff, M.D., Professor of Surgery, University of Florida College of Medicine, Gainesville

Questions and Answers

Adjournment

SECTION ON PEDIATRICS

(Co-sponsored by Florida Chapter, American Academy of Pediatrics, and Florida Pediatric Society)

Friday—2:00 p.m. to 5:30 p.m.

James A. Hallock, M.D., Tampa
Program Chairman

"Echocardiography," David G. Ruschhaupt, M.D., Division of Pediatric Cardiology, University Hospital, Jacksonville

"Approach to the Newborn with Heart Disease," Dolores F. Tamer, M.D., Assistant Professor of Pediatrics, University of Miami School of Medicine, Miami

Break

"Rheumatic Fever," Elia M. Ayoub, M.D., Professor of Pediatrics, University of Florida College of Medicine, Gainesville

"Hypertension in Children," Robert Levin, M.D., Miami

Discussion

Adjournment

SECTION ON OTOLARYNGOLOGY

(Co-sponsored by Florida Society of Otolaryngology)

Friday—2:00 p.m. to 5:00 p.m.

Herbert Fields, M.D., Hialeah
Program Chairman

Symposium on Medical and Surgical Treatment of Thyroid Disease

Moderator: Julian H. Groff, M.D., North Miami Beach

Panelists:

"Radiology in Thyroid Disease," Freddie P. Gargano, M.D., Chief Radiologist, Palmetto General Hospital, Hialeah

"Medical Evaluation of Thyroid Disease," Louis Chaykin, M.D., Endocrinologist, North Miami Beach

"Surgery of Thyroid and Parathyroid Glands," Julian H. Groff, M.D., ENT Surgeon, North Miami Beach

Coffee Break

Panel on Medical and Surgical Treatment of Sinus Disease

Moderator: Karl Morganstein, M.D., ENT Surgeon, Hollywood

Panelists:

"Radiology Diagnosis of Sinus Disease," Freddie P. Gargano, M.D., Chief Radiologist, Palmetto General Hospital, Hialeah

"Current Treatment of Sinus Disease," Karl Morganstein, M.D., ENT Surgeon, Hollywood

Adjournment

SECTION ON ENDOCRINOLOGY

(Co-sponsored by Florida Endocrine Society)

Friday—2:00 p.m. to 5:00 p.m.

Lawrence M. Fishman, M.D., Miami
Program Chairman

Program to be Announced

SPECIAL SCIENTIFIC PROGRAM FOR THE FMA AUXILIARY

(Sponsored by the FMA Committee on Continuing Medical Education)

Friday—3:00 p.m. to 5:30 p.m.

Thomas B. Thames, M.D., Orlando
Program Chairman

"Cardiovascular Disease for the Doctor's Wife"

"Nutrition and Cardiovascular Disease," Yank D. Coble, Jr., M.D., Clinical Associate Professor of Medicine, Division of Endocrinology and Metabolism, University of Florida College of Medicine (JHEP), and Chairman, FMA Committee on Continuing Medical Education, Jacksonville

"Physical Fitness and Cardiovascular Disease," Clarence H. Gilbert, M.D., Director of the Cardiac Catheterization Laboratory, Orange Memorial Hospital, Orlando

"Sexual Activity and the Cardiovascular Patient," Edward Spoto, M.D., Associate Professor of Internal Medicine, University of South Florida College of Medicine, Tampa

Questions and Answers

Adjournment

SECTION ON PATHOLOGY

(Co-sponsored by Florida Society of Pathologists)

Friday—4:00 p.m. to 5:00 p.m.

Morton J. Robinson, M.D., Miami Beach
Program Chairman

"The Role of the Pathologist in the Evaluation of Breast Cancer Screening Programs: Risks/Benefits of Mammography," Louis B. Thomas, M.D., Chief, Laboratories and Pathology, National Cancer Institute, Bethesda, Md.

Adjournment

SECTION OF INTERNATIONAL COLLEGE OF SURGEONS

(Co-sponsored by Florida State Surgical Division,
International College of Surgeons)

Friday—4:00 p.m. to 5:00 p.m.

Julian A. Rickles, M.D., Miami Beach
Program Chairman

"Clinical Use of Sympathetic Nerve Block," Julian A. Rickles, M.D., Acting Chief of General Surgery, Mt. Sinai Medical Center, Miami Beach

Questions and Answers

Adjournment

SATURDAY MORNING—MAY 7

SECTION ON RADIOLOGY SECTION II

(Co-sponsored by Florida Radiological Society)

Saturday—8:00 a.m. to 11:00 a.m.

Robert J. Mandel, M.D., Melbourne
Program Chairman

"Update: CAT Scanning of the Head," Freddie P. Gargano, M.D., Clinical Professor of Radiology, University of Miami School of Medicine, and Chief and Attending Radiologist, Palmetto General Hospital, Miami

"Update: CAT Scanning of the Body," Jerome J. Sheldon, M.D., Assistant Professor of Radiology, University of Miami School of Medicine, and Attending Radiologist, Mt. Sinai Hospital, Miami Beach

Break

"Nuclear Medicine and CAT Scanning: Competition and Teamwork," William M. Smoak III, M.D., Associate Professor, Division of Nuclear Medicine, University of Miami School of Medicine, and Attending Radiologist, Mt. Sinai Hospital, Miami Beach

Adjournment

SECTION ON ALLERGY AND IMMUNOLOGY

(Co-sponsored by Florida Allergy Society)

Saturday—8:00 a.m. to 12:30 p.m.

Roger J. Zwemer, M.D., Vero Beach
Program Chairman

"Theoretical Basis of Current Pharmacological Approaches in the Treatment of Asthma," Andor Szentivanyi, M.D., Professor and Chairman, Department of Pharmacology, University of South Florida College of Medicine, Tampa

"A Critical Review of Current Drug Therapy for Asthma," Elliot Ellis, M.D., Professor and Chairman, Department of

Pediatrics, State University of New York at Buffalo School of Medicine, Buffalo, N.Y.

Coffee Break

"Chronic Urticaria and Angioedema," Jose M. Quintero, M.D., Coral Gables

"The Role of Infection in Asthma," Elliot Ellis, M.D., Professor and Chairman, Department of Pediatrics, State University of New York at Buffalo School of Medicine, Buffalo, N.Y.

Adjournment

SECTION ON ORTHOPEDIC SURGERY (SECTION II)

(Co-sponsored by Florida Orthopedic Society)

Saturday—8:15 a.m. to 12:30 p.m.

Richard G. Onkey, M.D., Naples
Program Chairman

"Acute Hematogenous Osteomyelitis in the Growing Child," Greer Busbee III, M.D., Clarksville, Tenn.

Discussion

"Supracondylar Fractures of the Humerus in the Adult," Wallace E. Miller, M.D., Professor of Orthopedic Surgery, University of Miami School of Medicine, Miami

Discussion

"Osteotomy for the Treatment of Post-Traumatic Arthritis of the Knee Joint—Indications and Technique," Irwin M. Leinbach, M.D., St. Petersburg

Discussion

Coffee Break

"Slipped Capital Femoral Epiphyses in Blacks," John J. Jennings, M.D., Assistant Professor of Orthopedic Surgery, University of Miami School of Medicine, Miami

Discussion

"Management of Complications of THR," Roderick H. Turner, M.D., Massachusetts General Hospital, Boston, Mass.

Discussion

"Preliminary Study on Cervical Motion in Football Players," Arthur Pearl, M.D., Clinical Assistant Professor of Orthopedic Surgery, and Paul Mayer, M.D., Clinical Associate Professor of Orthopedic Surgery, University of Miami School of Medicine, Miami

Discussion

"Anterior Cervical Fusion Utilizing Freeze-Dried Cadaver Bone in Acute Spinal Cord Injury," Jerry E. Enis, M.D., Assistant Professor of Orthopedic Surgery, University of Miami School of Medicine, Miami

Discussion

"Spine Fusion—L4 to L5," George T. Rahilly, M.D., Ft. Lauderdale

Discussion

"Experiences with Functional Bracing of Humeral and Ulnar Fractures," Augusto Sarmiento, M.D., Professor and Chairman, Department of Orthopedic Surgery, University of Miami School of Medicine, Miami

Discussion

Adjournment

SECTION ON OBSTETRICS AND GYNECOLOGY

(Co-sponsored by Florida Obstetric and Gynecologic Society)

Saturday—8:30 a.m. to 11:30 a.m.

John E. Startzman, M.D., Orlando
Program Chairman

Papers from the Department of Obstetrics and Gynecology, University of Miami School of Medicine

Papers from the Department of Obstetrics and Gynecology, University of South Florida College of Medicine

Papers from the Department of Obstetrics and Gynecology, University of Florida College of Medicine

Adjournment

SECTION ON PEDIATRIC CARDIOLOGY

(Co-sponsored by Florida Association of Pediatric Cardiologists)

Saturday—8:30 a.m. to 11:30 a.m.

David G. Ruschhaupt, M.D., Jacksonville
Program Chairman

"Effect of Physical Training on Cardiac Function in Children," Elworth R. Buzkirk, Ph.D., Human Performance Research Laboratory, Pennsylvania State University, University Park, Pa.

Coffee Break

"Non-Invasive Evaluation in Transposition of the Great Arteries," Pedro L. Ferrer, M.D., University of Miami Hospitals and Clinics, and Assistant Professor of Pediatrics

"Vectorcardiographic Evaluation of Rheumatic Fever," Benjamin Victorica, M.D., Associate Professor of Pediatrics, University of Florida College of Medicine, Gainesville

"Septal Hypertrophy in Children," David G. Ruschhaupt, M.D., Division of Pediatric Cardiology, University Hospital, Jacksonville

"Cardiac Catheterization in a Community Hospital—1977 Update," Sidney Brodsky, M.D., Assistant Professor of Pediatrics, University of South Florida College of Medicine, Tampa

Adjournment

SECTION ON NEUROSURGERY

(Sponsored by Florida Neurosurgical Society)

Saturday—8:30 a.m. to 11:30 a.m.

Hubert A. Aronson, M.D., Miami
Program Chairman

Selected Papers by Members of the Florida Neurosurgical Society—Speakers and Topics to be Announced

Adjournment

SECTION ON RADIOTHERAPY

(SECTION II)

(Co-sponsored by Florida Radiological Society)

Saturday 9:00 a.m. to 10:15 a.m.

Phillip C. Smith, M.D., Gainesville
Program Chairman

"Effects of Adjunctive Chemotherapy on Normal Tissue Response and Complications in Radiotherapy Patients,"

Robert G. Parker, M.D., Immediate Past President, American Society of Therapeutic Radiologists, and Professor of Radiotherapy, University of Washington School of Medicine, Seattle, Wash.

"Carcinoma of the Base of the Tongue," Rodney R. Million, M.D., Professor and Chairman, Division of Radiotherapy, and Ed. C. Wright Professor in Clinical Oncology, University of Florida College of Medicine, Gainesville

Adjournment

SECTION ON DERMATOLOGY

(Co-sponsored by Florida Society of Dermatology)

Saturday—9:00 a.m. to 2:45 p.m.

Phillip Frost, M.D., Miami Beach
Program Chairman

Presentations by Residents in Dermatology at Mt. Sinai Medical Center, Miami Beach

Questions and Answers

"Application of Electron Microscopy to Clinical Diagnosis in Dermatology," Alvin S. Zelickson, M.D., Clinical Professor of Dermatology, University of Minnesota Medical School, Minneapolis, Minn.

Questions and Answers

"Surgical Treatment of Skin Cancer," Edward A. Krull, M.D., Chairman, Department of Dermatology, Henry Ford Hospital, Detroit, Mich.

Questions and Answers

Presentations by Residents in Dermatology at Mt. Sinai Medical Center, Miami Beach

Recess

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Adjournment

SECTION ON SURGERY

(Co-sponsored by Florida Chapter, American College of Surgeons, and Florida Association of General Surgeons)

Saturday—9:00 a.m. to 12:00 noon

John C. Fletcher, M.D., Tampa
Program Chairman

Panel Discussion to be Announced

"Hyperalimentation—Update," Stanley J. Dudrick, M.D., Professor and Chairman, Department of Surgery, University of Texas Medical School at Houston

Panel Discussion to be Announced

Adjournment

SECTION ON PLASTIC AND RECONSTRUCTIVE SURGERY

(Co-sponsored by Florida Society of Plastic and Reconstructive Surgery)

Saturday—9:00 a.m. to 12:00 noon

Jack D. Norman, M.D., Miami
Program Chairman

Papers on Selected Topics by Plastic Surgery Residents at the University of Miami School of Medicine

Papers on Selected Topics by Members of the Florida Society of Plastic and Reconstructive Surgery

Paper by Invited Out-of-state Guest Speaker

Adjournment

SECTION ON OPHTHALMOLOGY
(Co-sponsored by Florida Society of Ophthalmology)

Saturday—9:00 a.m. to 10:30 a.m.

Nicholas H. Kalvin, M.D., Naples

Program Chairman

"Marijuana Derivatives and Other Recent Medical Approaches to Glaucoma," Jonathan Herschler, M.D., Assistant Professor of Ophthalmology, Bascom Palmer Eye Institute and University of Miami School of Medicine, Miami

"The CAT Scanner in Ophthalmology," Donald Q. Vining, M.D., former Clinical Assistant Professor of Radiology, University of Miami, now Neuroradiologist, Naples Community Hospital, Naples

"Medical Therapy of Ocular Mycosis," L. Douglas Perry, M.D., Assistant Professor of Ophthalmology, University of South Florida College of Medicine, Tampa

Adjournment

SECTION ON PEDIATRIC SURGERY
(Co-sponsored by Florida Association of Pediatric Surgeons)

Saturday—9:30 a.m. to 12:15 p.m.

Burton H. Harris, M.D., Jacksonville

Program Chairman

Welcome—James L. Talbert, M.D., President, Florida Association of Pediatric Surgeons, Gainesville

Introduction of Guest Speaker—Burton H. Harris, M.D., Program Chairman and Moderator, Jacksonville

"1977 FAPS Lecture: Diaphragmatic Hernia," Thomas M. Holder M.D., Professor of Pediatric Surgery, Children's Mercy Hospital and the University of Missouri School of Medicine, Kansas City, Mo., and President, American Pediatric Surgical Association.

Coffee Break

"Esophageal Strictures in Children," Farhat Moazam, M.D., Fellow in Pediatric Surgery, University of Florida College of Medicine (JHEP), Jacksonville; James L. Talbert, M.D., Professor and Chief of Pediatric Surgery, and Bradley M. Rodgers, M.D., Associate Professor of Surgery and Pediatrics, University of Florida College of Medicine, Gainesville

"Hidden Appendicitis in Cystic Fibrosis," William T. Brown, M.D., Chief of Surgery, Variety Children's Hospital, Miami; and Leonard Roudner, M.D., Chief Resident in Surgery, Mt. Sinai Hospital, Miami Beach

"Management of Intractable Ascites in Budd-Chiari Syndrome," Nasim Ahmed, M.D., Attending Pediatric Surgeon, All Children's Hospital, St. Petersburg

"Prosthetic Porta-Systemic Shunts in Children," Farhat Moazam, M.D., Fellow in Pediatric Surgery; H. Warner Webb, M.D., Clinical Assistant Professor of Pediatric Surgery; Albert H. Wilkinson, Jr., M.D., Clinical Associate Professor of Pediatric Surgery, and Burton H. Harris, M.D., Clinical Assistant Professor of Pediatric Surgery, University of Florida College of Medicine (JHEP), Jacksonville

"Diagnosis and Management of Neurologic Deficits in Patients with Neuroblastoma," Mark Rosenfeld, M.D., Resident in Surgery, James L. Talbert, M.D., Professor and Chief of Pediatric Surgery, and Bradley M. Rodgers, M.D., Associate Professor of Surgery and Pediatrics, University of Florida College of Medicine, Gainesville

Adjournment

SECTION ON PHYSICAL MEDICINE AND REHABILITATION

(Co-sponsored by Florida Society of Physical Medicine and Rehabilitation)

Saturday—10:30 a.m. to 12:00 noon

Charles J. Kurth, M.D., Orlando

Program Chairman

"Acute Care of the Spinal Cord Injured Patient," Barth A. Green, M.D., Chief of Acute Spinal Cord Injuries Service and Assistant Professor of Neurological Surgery, University of Miami School of Medicine, and Assistant Chief, Acute Care Spinal Cord Injury Service, Veterans Administration Hospital, Miami

Adjournment

Cracker Cures

Cramps:

Dried eel skins tied around ankles for cramps.

One shoe stuck inside of other will prevent foot cramps.

Place shoes heel to toe and put under bed for leg cramps.

Wool string around ankle for cramps.

Reprinted by permission from "Cracker Cures," a publication by the Peace River Valley Historical Society. Edited by Cedric Stephen Wood, P.E. These cures have been collected over the years by friends and members of the Peace River Valley Historical Society and presented a few at a time at each of their regular meetings by Dr. Gordon H. McSwain, custodian.



Edward Jelks, M.D.
President, Florida Medical Association, 1937

Dr. Ed Jelks is dead.
His final illness was a short one;
His final days were full ones.

To the end he was a devoted husband to Miss Belle,
A gentleman to all whom he encountered,
A symbol of conscience and concern for his community,
A wise voice of experience for younger friends,
An on-going example of involvement in organized medicine,
His name a community synonym for the trusted physician.

This man worked to create the Florida Medical Association as we know it,
Participated in the formation of Blue Cross - Blue Shield,
Guided the surgical program of Duval Medical Center for many years,
Supervised the training of many Florida physicians,
Founded the first group practice in Florida.

Until his death he continued these interests and his sought advice was frequently a
basis for final decisions on medical and community matters.
Physicians everywhere have lost a friend. He was an example and inspiration to all
who would excel in their profession.

Thad M. Moseley, M.D.
Jacksonville

Dr. Jelks

Loved by his patients, respected by his colleagues, and revered by his residents, what kind of man was Dr. Jelks? Posterity will judge him by the material possessions he accumulated, the number of patients he cured, the number of boards on which he sat, the many hours working for organized medicine, and the years of loving care he spent attending his wife in her declining decade.

To this observer, through whose eyes he was watched for more than a quarter of a century in a relationship changing from the awe-stricken student's viewpoint as a first year resident, enduring through four years culminating in approving gazes as his last chief resident, through years of self-conscious glances as a contemporary practitioner, and finally to the two few years of respectful regard akin to a son-father companionship; he was always Dr. Jelks.

An idealist, he set high standards of professional knowledge, and while requiring each of his residents to spend six months in the pathology laboratory, he also taught us the art of the practice of surgery by serving as a living example of the physician who truly cared for each patient.

From Osler's teachings at Johns Hopkins he believed that medicine should be taught at the bedside, and on ward rounds his friendly warmth put every patient at ease when he began his interrogation, demonstrating how to appreciate the feelings of the patient without becoming emotionally so involved as to affect one's judgment. He was impatient with any member of the house staff who

failed to take an adequate history or do a careful physical examination. Although his fingers were crooked with arthritis, he had the gentlest touch when palpating a painful abdomen. Following the technique he learned from observing Dr. Halstead, he handled tissues with painstaking gentleness and closed wounds with precision. Assisting his resident across the table in the operating room, he cajoled us, made fun of us, and became angry at ineptness or clumsiness, but taught us to excel in the whole approach to surgical problems.

Denied children of his own, by example he taught us, "his boys," to stand up and be counted for the things that matter, to believe in life's enduring values and to give of one's talents, abilities, devotion and convictions to whatever venture we encountered.

In his final years, though slowed by the infirmities of the aged, he retained his mental facilities, reading each issue of the Journal of the FMA, going regularly to monthly meetings of the Duval County Medical Society and visiting Miss Belle daily at a nearby nursing home.

With no regrets and no remorse, living alone, he was content with his books and with visits to and from his many friends. He lived a full life, he accomplished much and will be missed by all those who knew and loved him.

Clyde M. Collins, M.D.
Jacksonville

Death Claims Dr. J. G. Converse Winter Haven Anesthesiologist

J. Gerard Converse, M.D., Winter Haven anesthesiologist and a Polk County delegate to FMA, died on February 5 after a sudden illness. He was 58.

A native of Boston, Mass., Dr. Converse received his M.D. degree at Tufts University in 1943. Before moving to Winter Haven, he was Professor and Chairman of Anesthesiology first at Albany

Medical School, then at the University of Miami. In 1973, he was named Vice Chairman of the Medical Liability Commission, which was organized by the American Medical Association and other medical organizations.

He was married to Gwendolyn S. Connor, M.D., also an anesthesiologist.

Dr. Richard T. Donelan Dead at 51

Richard T. Donelan, M.D., Editor of *Jacksonville Medicine* and a member of *The Journal's* Board of Consulting Editors, died at his home on January 18 after a long illness. He was 51.



Richard T. Donelan, M.D.

A native of Boston, Mass., Dr. Donelan received his M.D. degree from Tufts University School of Medicine. He took internship training at the U.S. Naval hospital, Bethesda, Md., and residency at the V.A. Hospital in Memphis, Tenn., and Henry Ford Hospital, Detroit.

A gastroenterologist, he practiced in Jacksonville since 1962.

Dr. Donelan served for four years as Editor of *Jacksonville Medicine*, resigning that post shortly before his death. He had been associated with *The Journal* since 1973, serving first as an Assistant Editor, then as a Consulting Editor.

In an editorial tribute published in the January issue of *Jacksonville Medicine*, the new Editor, Daniel B. Nunn, M.D., wrote, "I feel compelled to expose him as an articulate, fair-minded, courageous, unpretentious, stoic individual."

Dr. Donelan will always be thought of "as a quality human being who in allegorical fashion walks with words, runs and plays with phraseology and syntax, and waltzes with style," Dr. Nunn concluded.

Survivors include his wife, Mrs. Irene Donelan of Jacksonville; a daughter, Therese Donelan; three sons, Richard T. Donelan, Jr. of Tallahassee, Stephen M. Donelan of Jacksonville, and Peter A. Donelan of Tampa; a sister, Mrs. Helen Whelan of Boston; four brothers, Edward M. Donelan, Paul R. M. Donelan and John F. Donelan, all of Washington, D.C., and Mathias J. Donelan of Boston.

DEATHS

Branham, John C., Miami; born 1893; Columbia University, 1927; member AMA; died November 12, 1976.

Dediot, Luis G., Miami; born 1907; University of Havana, 1934; member AMA; died June 4, 1976.

Dick, Stanley F., Miami; born 1936; University of Miami, 1962; member AMA; died October 25, 1976.

Feirer, William A., Oklawaha; born 1900; Johns Hopkins University, 1930; member AMA; died November 4, 1976.

Fernandez, Joaquin M., Miami; born 1935; Havana/Salamanca, 1962; member AMA; died October 21, 1976.

Hood, J. Sudler, Clearwater; born 1908; University of Pennsylvania, 1933; member AMA; died September 12, 1976.

Krauss, Maurice D., Miami; born 1907; Jefferson Medical College, 1931; member AMA; died August 30, 1976.

Lovejoy, John F., Jacksonville; born 1907; Duke University, 1932; member AMA; died October 3, 1976.

Neefe, John R., St. Petersburg; born 1915; University of Pennsylvania, 1940; member AMA; died September 18, 1976.

Richards, Ferdinand, Jacksonville; born 1897; Medical College of Georgia, 1921; member AMA; died October 6, 1976.

Richardson, John R., Miami; born 1897; Emory University, 1924; member AMA; died September 13, 1976.

Robertson, James C., Vero Beach; born 1905; Emory University, 1928; member AMA; died October 20, 1976.

Smith, M. Crego, Clearwater; born 1908; Duke University, 1943; member AMA; died October 26, 1976.

Stewart, Russell T., Panama City; born 1915; Long Island College, 1940; member AMA; died July, 1976.



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The Reciprocal:

- Began providing insurance coverage January 1, 1977.
- Provides - \$500,000 - modified claims-made coverage with no aggregate.
- Is non-assessable.
- Retains loss exposure for the first \$100,000.
- Has reinsurance underwritten by the Lloyds of London and other underwriters for the remaining \$400,000.
- Provides automatic free conversion to an occurrence policy for death, disability, or normal retirement.
- Requires member participation in losses (20% or less - maximum is \$5,000.).
- Provides coordination of legal services and claims review.
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Letters to the Editor

To the Editor: I think the recent decision by Circuit Court Judge Dan Satin in the 11th Judicial Circuit, in and for Dade County in Florida, deserves the attention of all practicing physicians in our state. In Judge Satin's ruling, he dismissed with prejudice, a case presented by Attorney Rosenblatt of Miami. I quote in part from the Judge's order in this case:

"This court does not agree with the plaintiff's interpretation of this statute. There has been considerable legislative and judicial labor expended as a result of what has appeared to pose a threat to the continuing availability of health care in this state as a consequence to the soaring professional liability insurance premiums for Florida physicians. The legislative labors have resulted in the passage of Florida Statutes 768.133 and the judicial labors have resulted in the upholding of the constitutionality of this new medical mediation act.

"It appears abundantly clear to this court from an examination of the act itself, and its intent and purposes that the Florida Legislature intended that the Medical Mediation Panels provided for would conduct a hearing on the merits of the case before it. It appears to be imminently clear that the Legislature in its approach to the public health crisis in Florida, by this act, seeks to remove from the court system of this state those medical malpractice cases which are patently frivolous, or clearly meritorious, and those which are subject to settlement after the parties have been brought together with a disinterested mediator and to act as preliminary screening panels to determine issues of liability and damages. A compliance with this mediation procedure is and should be a jurisdictional prerequisite to the bringing of a medical malpractice suit in the courts of Florida.

"The procedure followed by the plaintiffs in this case attempt to make a mockery and a sham of the procedure enacted by the Legislature and upheld by the Supreme Court of Florida and appears to be a deliberate attempt to circumvent and evade the

provisions of the act. To permit and condone the procedure followed by the claimant before the medical mediation panel would make an absurdity of the act."

With these remarks the Judge dismissed the case with prejudice.

It seems apparent that in the view of this Circuit Court Judge he will not permit parties involved under the legislative Medical Mediation Panels to neglect their duty for any reason nor to obviate the intent of this law.

It is obvious from this decision that these panels should work to the good of honest and well meaning physicians as well as to their patient's good. I would urge, therefore, that all physicians participate in mediation panels when asked and render the most honest opinions possible.

Vernon B. Astler, M.D.
Immediate Past President
Florida Medical Association
Boynton Beach

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Medical News Around the State

The University of Miami has announced the staffing of its new Division of Nephrology. Jacques J. Bourgoignie, M.D., is Professor and Director of the Division. His staff will include: Leon G. Fine, Assistant Professor (M.D., University of Cape Town, 1966); Kuo Hwa Hwang, Research Assistant Professor (M.D., National Chekiang University School of Medicine, 1954); Michael Kaplan, Assistant Professor (M.D., Hadassah Medical School, Israel, 1966); and J. Phillip Pennell, Assistant Professor (M.D., University of Rochester, 1965).

FMA Committee on Continuing Medical Education . . . has recommended that Tallahassee Memorial Hospital's continuing medical education program be accredited provisionally for one year.

If approved by the AMA Council on Medical Education, TMH would be accredited from January 29, 1977 to January 28, 1978. The Hospital then would be authorized to sponsor or co-sponsor AMA Category 1 educational activities.

TMH is the third agency whose application has been acted upon favorably by the FMA Committee so far in 1977. Previously, it recommended the Florida Academy of Family Physicians and the Dade County Medical Association for accreditation.

A grant of \$299,644 . . . will finance continuation of a study of the role of the lungs in hormone metabolism at the University of Miami School of Medicine.

The grant, made by the John A. Hartford Foundation, of New York, brings to \$543,039 the total allotted by that organization to the project since 1972.

James W. Ryan, M.D., Associate Professor of Medicine, and Una S. Ryan, M.D., Assistant Professor of Medicine, are principal and co-principal investigators, respectively.

Morris Walsman, M.D., of Tampa . . . has been elected Vice President of the American Academy of Dermatology.

The election was held at the conclusion of the Academy's 35th Annual Meeting in Chicago on December 9. A graduate of the University of Minnesota School of Medicine, Class of 1937, Dr. Walsman serves as an Associate Professor of Dermatology at both the University of Miami and University of South Florida medical schools.

Charles K. Donegan, M.D., of St. Petersburg . . . has been appointed Speaker of the House of Delegates for the Annual Meeting of the American Society of Internal Medicine this month.

The session will be in Kansas City, Mo., March 23 - 27. The appointment was made by ASIM President William Felts, M.D.

Dr. Donegan is a Past President of ASIM and served a previous term as Speaker. He is a former Speaker of the House of Delegates of the Florida Medical Association and at present he is a Florida delegate to the American Medical Association and Florida Governor for the American College of Physicians.

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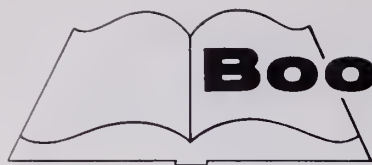
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Book Reviews

Book Review Editor

F. Norman Vickers, M.D.

Why Drinking Can Be Good for You by Morris L. Chafetz, M.D. 190 Pages. Price \$8.95. Stein & Day, New York, 1976.

Winston Churchill, noted for his heavy use of alcohol, said " . . . I have taken more good from alcohol than alcohol has taken from me." Thus begins Chafetz' book. Rest assured that this monograph is not an apology for excessive drinking.

The author has excellent credentials—former Director of National Institute on Alcohol Abuse and Alcoholism with teaching appointments at Harvard and Johns Hopkins. His book is constructed along the lines popularized by "Everything You Wanted to Know about Sex*" and is a carefully balanced, authoritative statement of what we know about alcoholism today. Alcoholism, according to Chafetz, is the most serious drug abuse problem this nation faces.

Although written in a style which will appeal both to the lay person and the professional, this book will not likely change the habits of the compulsive drinker who is, by this time, unresponsive to gentle prodding and conversion by facts or logic.

An interesting facet of the book is Chafetz' thesis that nondrinkers may also be caught up in the alcohol problem. His example is Carry Nation who "couldn't take care of her daughter, couldn't live with her husband because she was obsessed with Demon Rum." The basic idea is that if someone is either in favor of or against liquor so that these sentiments influence his public and private behavior, then that unhappy creature is on the horns of a serious alcohol dilemma. Chafetz first published this idea in the Johns Hopkins magazine under the whimsical title "Cary Nation Had a Drinking Problem." It was subsequently reprinted by the Sunday/Miami Herald.

For the price of \$8.95, and a quiet evening at home, this little book will not only amuse and entertain you, it will effectively teach you some things every physician should know about alcoholism* (even if he is afraid to ask).

Jose J. Llinas, M.D.
Gainesville

Dr. Llinas is Executive Director of North Central Florida Community Mental Health Center and Professor of Psychiatry at University of Florida.

The Healers: The Rise of the Medical Establishment by John Duffy. 385 pages. Price \$12.50. New York, McGraw-Hill Book Company, 1976. No illustrations.

The physician, novelist, science writer or educated layman who wants a highly readable and yet authoritative account of the history of medicine in the United States will find this a delightful book. While not bogged down in details, it provides information sufficient for the history buff and cites sources which permit the more serious student to dig deeper. This writer would pick a bone with the author on two points: at times the text is repetitious, perhaps this stems from the organization of the book, and I looked in vain for the slightest mention of the development of Florida medicine. Florida was the site of the first European settlement in the United States and a number of articles about its medical history have been published.

William M. Straight, M.D.
Miami

Dr. Straight is the Historical Editor of the Journal and is in the private practice of Internal Medicine in Miami.

Books Received

Receipt of the following books is acknowledged. Medical readers interested in reviewing particular books are invited to address requests to the Book Review Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.

Social Responsibility: Journalism, Law, Medicine, Volume II, edited by Louis W. Hodges. 104 Pages. Price \$2.50. Washington and Lee University, Lexington, Virginia, 1976.

A Laboratory Manual for Rural Tropical Hospitals by Monica Cheesbrough and John MacArthur. 209 Pages. Illustrated. Price \$7.50. Churchill Livingstone, New York, 1976.

Current Medical Diagnosis & Treatment, 16th Revision, by Marcus A. Krupp, M.D. and Milton J. Chatton, M.D. 1,066 Pages. Price \$16.00. Lange Medical Publications, Los Altos, Calif., 1977.

Review of Medical Pharmacology, 5th Edition by Frederick H. Meyers, M.D., Ernest Jawetz, Ph.D. and Alan Goldfien, M.D. 740 Pages. Illustrated. Price \$12.50. Los Altos, California, Lange Medical Publications, 1976.

Correlative Neuroanatomy & Functional Neurology, 16th Edition by Joseph G. Chusid, M.D. 448 Pages. Illustrated. Price \$10.00. Los Altos, California, Lange Medical Publications, 1976.

Current Pediatric Diagnosis and Treatment, 4th Edition, by C. Henry Kempe, M.D., Henry K. Silver, M.D. and Donough O'Brien, M.D. 1,053 Pages. Illustrated. Price \$15.00. Los Altos, California, Lange Medical Publications, 1976.

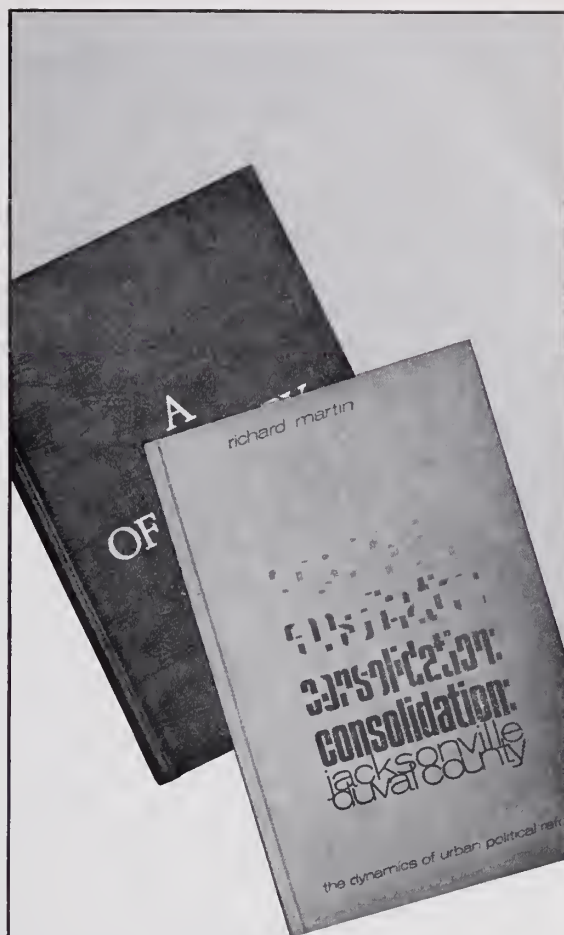
Nuclear Energy and National Security by the Research and Policy Committee of the Committee for Economic Development. 80 Pages. Illustrated. Price \$2.50 paperbound, \$4 hardbound. New York, Committee for Economic Development, 1976.

Coordinated Ambulatory Care, The POMR by Jefferson J. Vorzimer, M.D. 128 Pages. Price \$7.50. Appleton-Century-Crofts, New York, 1976.

Current Obstetric & Gynecologic Diagnosis & Treatment by Ralph C. Benson, M.D. and Associate Authors. 912 Pages. Price \$16.00. Lange Medical Publications, Los Altos, Calif., 1976.

Growth, Maturation, and Aging by Tadayoshi Imaizumi. 118 Pages. Sugiyama-ku, Tokyo, Kugayama Press, 1976.

The Water Jump—The Story of Transatlantic Flight by David Beaty. 304 Pages. 140 Illustrations. Price \$10.00. Harper & Row, Publishers, Inc., New York, 1977.



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Farewell, Mr. Solomon

The name of Crawford Solomon Sr. will not strike a familiar chord with most Florida physicians.

But when he died last month at the age of 60 *The Journal* lost one of its closest, most loyal friends.

Mr. Solomon was owner and board chairman of Jacksonville's Convention Press, a firm founded by his father which had produced this magazine continuously since 1938.

A native of Mississippi, Mr. Solomon arrived in Jacksonville in 1931, when his father, the Rev. Edward D. Solomon, became Editor of *The Florida Baptist Witness*. That publication is still printed at Convention Press, and indeed it was no secret that *The Witness* and *The Journal* occupied a special place in his heart.

He often arrived unannounced at the FMA Headquarters to tell the staff editors about a recent trip, or a new piece of equipment he had purchased for his plant, and to learn first hand how things were going with *The Journal* from the FMA point of view. He delighted in leading tours through his company and in entertaining customers at his spacious riverfront home.

When the recession of the early 1970s struck, the future of many printing companies was threatened, and Mr. Solomon vowed that Convention would weather the storm. And survive it did.

In the rare instances when something went wrong with his part of producing *The Journal*, he was personally embarrassed by it, and the sky seemed to be the limit in making amends.

Mr. Solomon's medical ties extended beyond *The Journal*. His parents were leaders in the development of Baptist hospitals in the South, including Jacksonville's Baptist Hospital. And Crawford Solomon himself once served as Chairman of the Board of Duval Medical Center, which evolved into University Hospital of Jacksonville.

Locally, he was active in the civil rights movement. As Board Chairman of the Jacksonville Urban League in the 1950s and before and after he urged the hiring of blacks for jobs that had been closed to them. He set an example with his own company.

Two months before his death, Mr. Solomon turned over the management and presidency of his Company to a close associate, and devoted most of his time to sales and promotion. He seemed to be having a real wonderful time traveling about and promoting a cookbook produced by the Junior Woman's Club of President Carter's hometown of Plains, Ga., to which his company had acquired rights.

Crawford Solomon Sr. was a man who loved life and savored every moment of it. His own life ended suddenly, peacefully and unexpectedly as he slept in the early morning of Saturday, February 12.

It is a tribute to the man that on the day of his death his employees worked overtime on the printing of the February issue of *The Journal*.

The editors of *The Journal* share with Mrs. Solomon and sons Crawford Jr. and James the burden of this loss.

So long as we love, we serve.

So long as we are loved by others,

I would almost say we are indispensable;

And no man is useless while he has a friend.

R. L. Stevenson

MEETINGS

Approved by FMA Committee on Continuing Medical Education

MARCH

Basic Medical Hypnosis, Mar. 13-19, Miami*

Gynecologic Oncology Seminar, Mar. 15-26, Cruise*

Tenth Anniversary JHEP Instructional Course on Surgery of the Hand, March 16-20, Amelia Island. For information: Ira M. Dushoff, M.D., 580 W. 8th St., Jacksonville 32209.

Neurology for Non-Neurologist V: Movement Disorders, March 17, Tampa.+

Mease Hospital Tumor Board, March 17, Mease Hospital, Dunedin. For information: Paul S. Berger, M.D., 725 Virginia Street, Dunedin 33528.

The Tallahassee Medical Seminar, Mar. 17, Joe's Steak House, Tallahassee.

Seventh Annual Special Radiological Procedures Seminar, Mar. 19-22, Konover Hotel, Miami Beach.*

Fifteenth Annual Clinical Radiology Seminar, Advances in Cancer Diagnosis, Mar. 22-26, Konover Hotel, Miami Beach.*

9th Teaching Conference in Clinical Cardiology, Mar. 23-26, Sheraton-Four Ambassadors Hotel, Miami.*

Diabetes Mellitus, Mar. 23, Beaches Hospital, Jacksonville Beach. For information: K. Ioannides, M.D., 1430 - 16th Ave., S., Jacksonville Beach 32250.

8th Annual Topics in Internal Medicine, Mar. 24-26, Hilton Hotel, Gainesville**

Cardiology, March 25-27, Contemporary Hotel, Lake Buena Vista. For information: Jonathan O. Partain, M.D., 1131 South Orange Avenue, Orlando 32806.

Post-Conventional Seminar, Pathologic-Radiologic Correlations, Mar. 26-29, Caribbean Cruise.*

2nd Annual Vail Conference in Respiratory Therapy, Mar. 26-Apr. 2, Miami*

Pulmonary Infection, Pulmonary Infarction (Embolus), Mar. 26-27, Tampa.+

Diagnostic Therapeutics '77, Mar. 26-27, Bahia Mar Hotel & Yachting Resort, Fort Lauderdale. For information: M. J. DeAlmolda, M.D., 4330 W. Broward Blvd., Fort Lauderdale 33317.

Cardiac Catheterization Conference, Mar. 28, Holy Cross Hospital, Fort Lauderdale. For information: J. R. Fichtelman, M.D., 4725 N. Federal Hwy., Fort Lauderdale 33308.

Hepatitis: Diagnosis and Management, Mar. 31, Tampa.+

Frontiers in Ultrasound, Mar. 31-Apr. 2, Konover Hotel, Miami Beach. For information: Mrs. June Allen, Conference Coordinator, Mt. Sinai Medical Center, 4300 Alton Road, Miami Beach 33140.

APRIL

Infectious Disease and Chemotherapy for the Practicing Physician, Apr. 1-2, Hyatt House, Kissimmee. For information: Barry E. Sieger, M.D., 1416 S. Orange Ave., Orlando 32806.

Third Annual Meeting, American Spinal Injury Association, Apr. 4-6, Dutch Inn, Lake Buena Vista. For information: J. D. Shea, M.D., 115 W. Columbia, Orlando 32806.

Joint Replacement, Apr. 6, Beaches Hospital, Jacksonville Beach. For information: K. Ioannides, M.D., 1430 - 16th Ave., S., Jacksonville Beach 32250.

Medical Knowledge Self-Assessment Course, Apr. 6, 13, 20, 30, Borland Medical Library, Jacksonville. For information: JHEP, 655 W. 8th St., Jacksonville 32209.

Cardiology Update—1977, Apr. 8-9, Sheraton Inn, Jacksonville Beach. For information: JHEP, 655 W. 8th St., Jacksonville 32209.

Ninth Congress of the International Federation of Fertility Societies, Apr. 13-16, Fontainebleau Hotel, Miami. For information: Robert W. Kistner, M.D., c/o Ms. Pat Shannon, Exec. Sec., American Fertility Society, 1608 13th Avenue, S., Birmingham, Alabama 35205.

Practical Electrocardiography and Arrhythmia Management for the Family Practitioner, Apr. 14-16, Hilton Hotel, Gainesville**

Recent Advances in Endocrinology III, Apr. 20-21, Hilton Hotel, Jacksonville. For information: JHEP, 655 West 8th St., Jacksonville 32209.

Postgraduate Seminar on Arthritis & Related Diseases, April 21-23, Hilton Hotel, Jacksonville. For information: Louis M. Sales, M.D., 2522 Oak Street, Jacksonville 32205.

Mease Hospital Tumor Board, April 21, Mease Hospital, Dunedin. For information: Paul S. Berger, M.D., 725 Virginia Street, Dunedin 33528.

Treatment of Adolescents with Behavior Disorders, Apr. 21, Kapoktree Inn, Fort Lauderdale. For information: Peggy Jackson, 330 Southwest 27th Avenue, Fort Lauderdale 33312.

Sixth Annual Cardiovascular Consecutive Case Study, Apr. 22-24, Amelia Island Plantation. For information: T. O. Gentsch, M.D., 1150 N.E. 14th St., Miami 33136.

*For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152, Tel. (305) 547-6716.

**For Information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143.

+For Information: Contact Theron A. Ebel, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2074.

Family Practice Weekend, Apr. 22-24, Gainesville Hilton Inn, Gainesville. For information: Florida Academy of Family Physicians, 4057 Carmichael Avenue, Jacksonville 32207.

Respiratory Dynamics, Apr. 27, Beaches Hospital, Jacksonville Beach. For information: K. Ioannides, M.D., 1430 16th Ave., S., Jacksonville Beach 32250.

Common Problems In Ocular-Plastic Surgery, Apr. 30, Tampa+

MAY

Florida Medical Association 103rd Annual Meeting, May 4-8, Americana Hotel, Miami Beach.

Master Approach to Cardiovascular Problems, May 5-7, The Contemporary Hotel, Walt Disney World**

Asymptomatic Coronary Artery Disease: Early Detection and Management, May 12-14, Innisbrook Resort, Tarpon Springs**

Mease Hospital Tumor Board, May 19, Mease Hospital, Dunedin. For information: Paul S. Berger, M.D., 725 Virginia Street, Dunedin 33528.

Fifth Family Practice Review, May 23-27, Hilton Hotel, Gainesville**

JUNE

Florida Suncoast Pediatric Conference, Second Annual Meeting, June 12-15, Sheraton Sand-Key, Clearwater Beach+

Mease Hospital Tumor Board, June 16, Mease Hospital, Dunedin. For information: Paul S. Berger, M.D., 725 Virginia Street, Dunedin 33528.

Twenty Eighth Annual Scientific Assembly, June 22-26, Sandpiper Bay, Port St. Lucie. For information: Florida Academy of Family Physicians, 4057 Carmichael Avenue, Jacksonville 32207.

Post Assembly Seminar, June 26-July 3, Snow Mass, Colorado. For information: Florida Academy of Family Physicians, 4057 Carmichael Avenue, Jacksonville 32207.

JULY

The Problem of Infertility, July 11, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge, M.D., 511 W. Highland Blvd., Inverness 32650.

SEPTEMBER

Tips, Tricks, Traps and Techniques, Sept. 9-11, Sea Turtle Inn, Jacksonville Beach. For information: Duke H. Scott, M.D., 1205 Beach Boulevard, Jacksonville Beach 32250.

The Problem of Microscopic Hematuria, Sept. 12, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge, M.D., 511 W. Highland Blvd., Inverness 32650.

NOVEMBER

The Problem of Glaucoma, Nov. 14, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge, M.D., 511 W. Highland Blvd., Inverness 32650.

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We therefore join members of the American business community in agreement that:

1. Our employees' job and career opportunities will not be limited or reduced because of their service in the Guard or Reserve;
2. Our employees will be granted leaves of absence for military training in the Guard or Reserve without sacrifice of vacation time; and
3. This agreement and the resultant policies will be made known throughout the organization and announced in publications and through other existing means of communication.



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Because—it means less disruption of normal business and civilian life than caused by the draft.

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Join other members of the American business community in agreement that:

1. Our employees' job and career opportunities will not be limited or reduced because of their service in the Guard or Reserve.

2. Our employees will be granted leaves of absence for military training in the Guard and Reserve without sacrifice of vacation time; and

3. This agreement and the resultant company policies will be made known throughout the organization and announced in company publications and through other existing means of communication.

To receive your Statement of Support, or get further details, write to: National Committee for Employer Support of the Guard and Reserve, 400 Army-Navy Drive, Arlington, Va. 22202.

Or call: 202-697-6902.

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Employer Support of the Guard and Reserve

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FEMALE PHYSICIAN, OB-GYN BOARD ELIGIBLE, FMG, full U.S. training. Interested group practice, partnership or full time position Broward County or vicinity. Write C-787, P.O. Box 2411, Jacksonville, Florida 32203.

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GENERAL SURGEON AND INTERNAL MEDICINE—35, both board certified. Husband, experienced director of a busy municipal emergency room F.A.C.S., ACEP member. Wife with cardiology subspecialty. Desire to relocate in Florida. Will consider community that needs to build emergency medicine. Practice either solo, group or salary. Write C-780, P.O. Box 2411, Jacksonville, Florida 32203.

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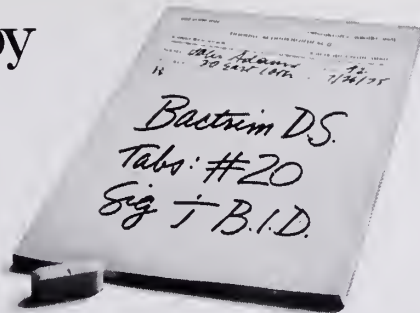
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10-day Bactrim therapy outperforms 10-day ampicillin therapy.



In a multicenter, double-blind study of patients with chronic or frequently recurrent urinary tract infection, Bactrim 10-day therapy outperformed ampicillin 10-day therapy by 27.2%, when comparing patients who maintained clear cultures for eight weeks. Criterion for "clear culture" was 1000 or fewer organisms/ml of urine.

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Note: Bactrim tablets were used in these clinical trials. Bioequivalence studies show one Bactrim DS double strength tablet is equivalent to two Bactrim tablets.

For chronic or frequently recurrent cystitis and pyelonephritis due to susceptible organisms.

Before prescribing, please consult complete product information, a summary of which follows:

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NOTE: The increasing frequency of resistant organisms limits the usefulness of antibacterials, especially in these urinary tract infections. The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. **Data are insufficient to recommend use in infants and children under 12.**

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprolthrombinemia and methemoglobinemia. *Allergic reactions:* Erythema

BactrimTM DS

(160 mg trimethoprim and 800 mg sulfamethoxazole)

Double Strength tablets

Just 1 tablet B.I.D.

BactrimTM

(80 mg trimethoprim and 400 mg sulfamethoxazole)

2 tablets B.I.D.



multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for children under 12. Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) every 24 hours
Below 15	Use not recommended

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10.

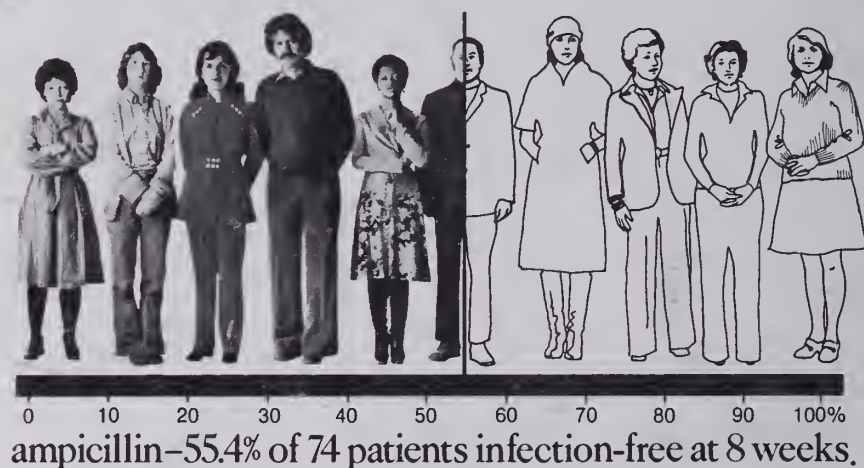
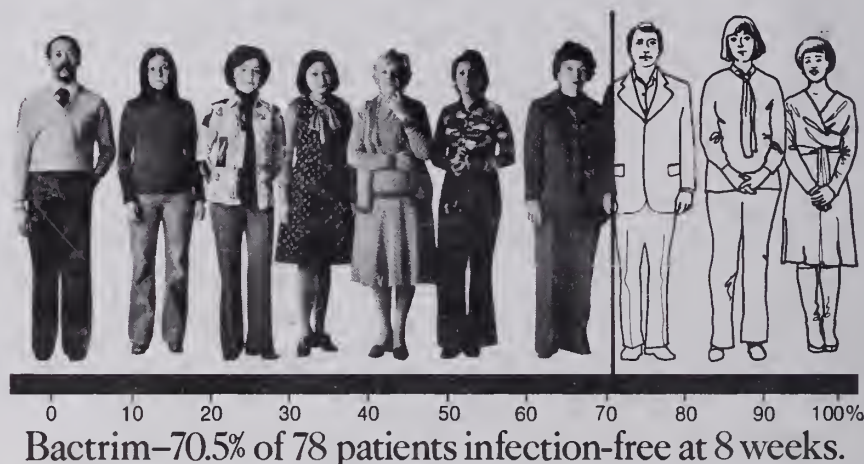
Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole; fruit-licorice flavored—bottles of 16 oz (1 pint).



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Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

In a multicenter study of patients with chronic or frequently recurrent urinary tract infection

Bactrim was 27.2%* more effective than ampicillin in keeping patients infection-free for 8 weeks.†



*This percentage is arrived at by the statistical method of dividing the difference between Bactrim and ampicillin results (15.1%) by the percent of ampicillin results (55.4%).

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BactrimTM DS Double Strength tablets
(160 mg trimethoprim and 800 mg sulfamethoxazole)

Please see summary of product information on preceding page.



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Summary of Board of Governors' Meeting, March 18-20, 1977, Page 238a
The FMA's Continuing Medical Education Program —
What Every Member Should Know, page 269

THE ANXIETY-SPECIFIC.

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- three dosage strengths meet most patient needs

LIBRIUM® chlordiazepoxide HCl/Roche 5mg, 10mg, 25mg capsules

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psycho-

Libritabs® (chlordiazepoxide) available in 5 mg, 10 mg and 25 mg tablets.



tropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relation-

ship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. **Oral—Adults:** Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* (*See Precautions.*)

Supplied: Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.



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APRIL COVER — The cover is a collage of the State Capitol Building in Tallahassee and our two physician legislators, Dr. Richard S. Hodes, of Tampa, (upper left), Representative from Hillsborough County; and Dr. David J. Lehman, of Hollywood, Representative from Broward County.



President's Page

"New Jersey M.D.'s Vote to Reject Local PSRO"

Perhaps these headlines in the American Medical News, December 20-27, 1976, should have been three inches high across the front page, instead of buried on page 15. This was the second doctor-formed PSRO voted out by its doctors after closer scrutiny, and raises an interesting question. Why are doctors in some areas rushing headlong into a program, while other doctors already involved are rushing out?

The two reasons most commonly presented for doctors establishing a PSRO are, (1) it is the law of the land, and (2) if we don't do it someone else will. In answer to #1, the law does not require physicians to establish PSRO's, it merely allows them to do so if they so desire. Regarding the second reason, if some other group is designated to establish the PSRO, the law designates that the peer review activities carried out by doctors in their respective hospitals shall be accepted as satisfying that portion of the law dealing with peer review, providing it is done properly. This requires determining the necessity of admissions to the hospital, the quality of care rendered in the hospital, and the efficient use of hospital facilities, namely, proper utilization. Thus, through Medical Audit, as required by Joint Commission, we are already fulfilling the only portion of the law in which we should be involved, namely, peer review. The other portions of the law do not deal with physician activities, and are not within his expertise. For those who have projected the PSRO as a possible learning experience, this is already in progress in the Medical Audit.

Conversely, a number of reasons exist for not becoming involved. Virtually everyone in the profession, from the AMA down to each individual physician who has familiarized himself with the law, agrees that it is a bad law. Despite considerable effort by the AMA to amend and improve the law, it has not been changed since its passage and remains the same bad law. Its more onerous aspects are not being enforced at the present time so as not to create strife until the individual units are better ensconced in their respective communities. Its proponents speak of it as improving the quality of medical care, but the words of the law speak toward cost control, and in an inflationary economy and increased demands for service the two are incompatible.

One often hears the statement that if we are involved as the PSRO unit we will have "input" into the system. We have only to observe the years Blue Shield begged HEW to change the wording, "more than the allowable charge," regarding physicians' charges to have a more realistic appraisal of what "input" the PSRO unit will have into the system. Permitting an aside, look at the plight of Blue Shield. In 1966 this highly respected, Florida doctor-sponsored health insurance company was asked by the Florida House of Delegates to become the fiscal intermediary for the Medicare program. In carrying out the dictates of the Washington bureaucrats, (and with virtually no "input"), it has become the target of criticism for every shortcoming of the Medicare program by physician and patient alike. The rules come down from Washington to whatever designated group has established the programs, and they are expected to be enforced by such group. Thus, to ask FMA to become the state coordinating agent for PSRO activities in Florida, and act as the enforcer and defender of regulations sent down from Washington, would in fact sound its death knell. It doesn't take much imagination to go one step further and visualize eventually taking the FMA to court over disputes which would arise.

At the AMA meeting in Philadelphia in December, 1976, the organization of state medical society officers was told by Doctor Hellman, head of the PSRO agency in HEW, that the program can not be carried out without the physicians. This same feeling was corroborated by a team of Yale researchers commissioned by Congress to study the PSRO program as reported by Medical World News, November 1, 1976. Furthermore, it is apparent that the HSA and the PSRO are the cornerstones for a National Health Scheme, and it is felt that they should be functioning before we embark on such a scheme.

Why then as physicians should we set a cornerstone for our own take over? I commend and applaud our House of Delegates on its wisdom in twice refusing to be stampeded into embracing a bad law which would require the FMA to become the hatchet-man against its own members, the doctors of Florida.

Jack A. Walvis, MD



RECENT CHANGES

federal register

**Providing
Drug Information
to Physicians**

**Informational
Bulletin #433-76**

**National
Health
Insurance**

special report
**Malpractice
insurance:**

**drug
bulletin**

**Health care doesn't
need more red tape**

**Drug firms challenge
MAC rules**

**Drug
Substitution**

**The Common Denominator
of Health Progress
RESEARCH**

Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

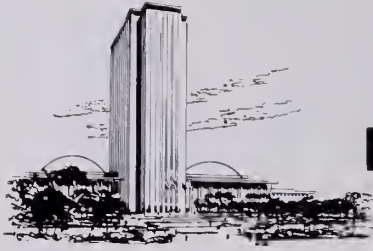
The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005



LEGISLATIVE NEWS

Legislative Efforts for 1977

The opening of the 1977 Session of the Florida Legislature finds the Florida Medical Association with a fully staffed Capital Office with a competent cadre of consultants.

Scotty Fraser and George Palmer handle most of the legislative contact work assisted by FLAMPAC Executive Director, Phil Gilbert, during the session. Nancy Moreau, with four years of legislative staff experience, provides the capability for instant analysis and research of the more than 300 health bills filed each session. Consultants working with this full-time team are Tallahassee attorneys John French, Bob Fokes and Mallory Horne. Staff support services are provided by three capable secretaries, Gail Ricks, Marianne Jowers, and Nedra Kwader.

The physical facilities are comfortable, efficient and extremely well decorated. The office provides an ideal place for legislative conferences and meetings for small groups of physicians in the Capital city for business. When next in Tallahassee, we urge you to come by and view the office and meet your staff.

Efforts have long been underway to develop support for the Association's 1977 legislative objectives "Priority 77." Briefings were conducted in most counties with members of the legislative committees and key contact physicians and information packets were distributed to contact physicians for their assigned legislators. The objectives assigned by the called meeting of the House of Delegates are controversial, but most important. If we are to succeed, it will take maximum effort by our key contact physicians and staff, and it is hoped that by the time this article is published that the necessary support will have been generated through this "grassroots" approach. As last year, our efforts will peak and fall many times before we finally come to that "moment of truth" in the conference committee.

Let's not forget, however, that there are many other important programs to be passed, and several measures to be defeated! **Among the proposals to pass are:**

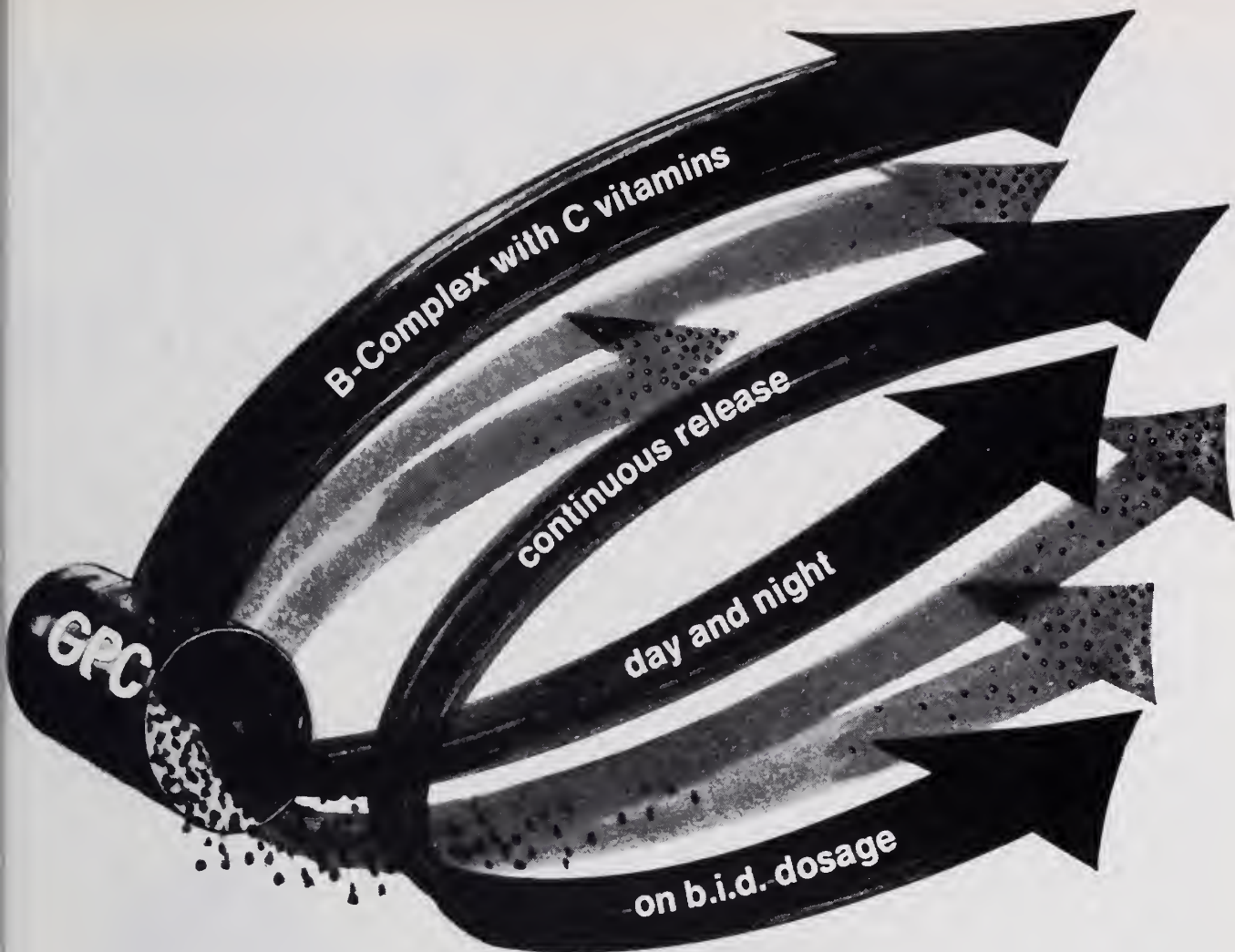
1. Improvement of emergency medical services by:
 - a. Physician supervision of EMT II's.
 - b. Increased funding for Advanced Life Support Systems and CPR.
2. Development and support of Perinatal programs at existing neonatal regional centers.
3. Increased funding for primary care residency training programs.

4. Improvements in Florida's Medicaid program by:
 - a. Implementation of a peer medical utilization review program through appropriation of sufficient funds to enable Department of HRS to contract with private medical foundations to conduct PMUR for Medicaid as has been successfully done for Medicare.
 - b. Adoption of realistic reimbursement schedule for physicians and other providers. (Present physician schedule based on 1971 Relative Value Study.)
5. Authorization for Department of HRS to implement statewide fluoridation program.
6. Transfer of restaurant health inspections from Department of Business Regulation to Department of HRS.
7. Standardized health claim forms for all insurance companies and government programs.
8. Regulation of Diagnostic Health Testing Centers.
9. Prohibition against use of drugs by optometrists.

Among the measures the FMA is working to defeat are:

1. Certificate of need and licensure for selected items of equipment in physicians' offices. (CAT scanners, radiation therapy units, and cardiac catheterization labs)
2. State commission to regulate hospital and nursing home rates.
3. Limited hospital privileges for chiropractors.
4. Legislative changes in physicians' billing systems and other office operations. (SB 81)
5. Attempts to weaken the State Board of Medical Examiners by:
 - a. Placement of consumers on the Board
 - b. Creation of loopholes to bypass normal licensure requirements
6. Legislation which requires the Department of HRS to establish a health information system. (The private sector through the Florida Health Data Corporation can more efficiently do the job.)

Remember, when all the "firing" is over, medicine's achievement in the legislative arena depends upon the local medical society and key contact physicians. Your Council on Legislation and Regulations appreciates the support given by each of you during the past year.



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This semiannual journal presents in abstract form recent periodical publication in the subject areas named.

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Summary of FMA Board of Governors Meeting March 18-20, 1977

The following is a summary of the actions taken by the Board of Governors at its meeting on March 18-20, 1977.

THE BOARD:

ANNUAL MEETING DATES

Approved the following future Annual Meeting dates of the Association:

1979	May 2-6	Orlando
1980	May 7-11	Diplomat Hotel
1981	May 6-10	Americana Hotel
1982	May 5-9	Diplomat Hotel
1983	May 4-8	To be selected
1984	1st week	Diplomat Hotel in May

FMA SPECIAL ASSESSMENT

Approved a policy that those physicians joining the Association after September 30, 1976, be assessed 50% of the full FMA special assessment.

EDITOR FMA JOURNAL

Unanimously approved the President-Elect's selection of Gerold L. Schiebler, M.D., for re-appointment as editor of the FMA Journal for 1977-78.

AMA COUNCILS AND COMMITTEES

Submitted nomination of Florida physicians to the AMA for appointment or re-appointment to the AMA Councils and Committees.

COUNCIL ON SPECIALTY MEDICINE

Approved the application of the Florida Federation of Clinical Oncologists for recognition by the FMA.

COMMITTEE ON VOLUNTARY HEALTH AGENCIES

Approved official FMA recognition be renewed for 1977-78 for the following Voluntary Health Agencies:

1. The Arthritis Foundation, Florida Chapter
2. Leukemia Society of America, Florida Division
3. American Heart Association, Florida Affiliate
4. American Cancer Society, Inc., Florida Division
5. National Foundation, March of Dimes
6. Florida Lung Association
7. Easter Seal Society For Crippled Children and Adults of Florida, Inc.
8. National Multiple Sclerosis Society, Southeast Region
9. Florida Society for the Prevention of Blindness, Inc.
10. Florida Coordinating Council of the National Kidney Foundation

Approved tentative recognition for the following Voluntary Health Agencies and authorized the chairman of the Committee on Voluntary Health Agencies to make the final determination as to these agencies, pending review of the additional information requested by the committee.

1. Florida Epilepsy Foundation, Inc.
2. Florida Association for Retarded Citizens
3. United Cerebral Palsy of Florida, Inc.
4. Mental Health Association of Florida Inc.
5. Muscular Dystrophy Association, Inc., Florida District

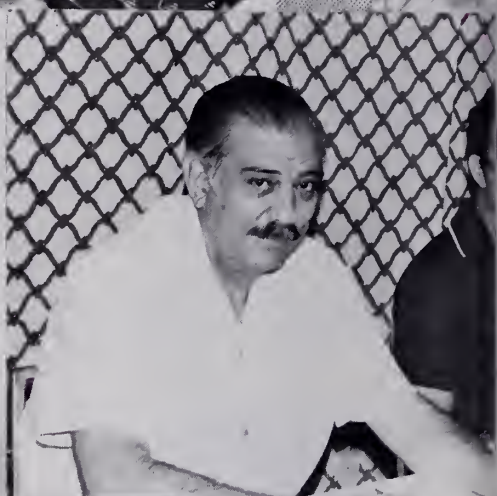
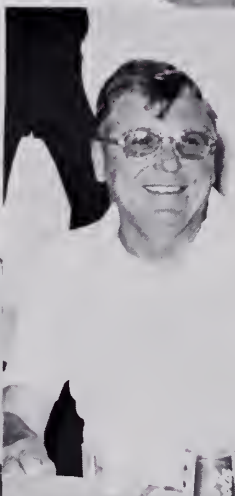
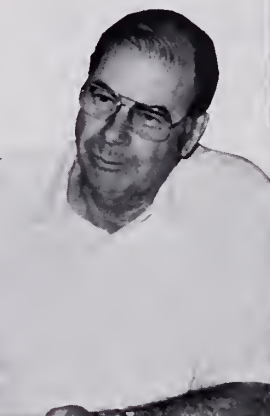
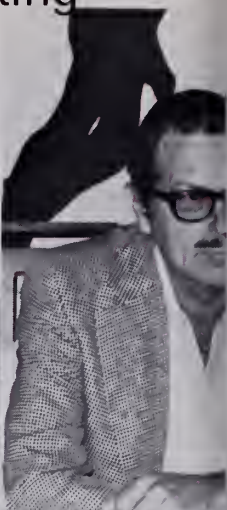
Candid Shots at the March Board of Governors Meeting

At right: FMA Secretary Robert E. Windom, M.D., Sarasota; and Vice President O. William Davenport, M.D., Miami.

2nd row: Board members Joseph G. Matthews, M.D., and Benjamin M. Cole, M.D., both of Orlando; FMA Executive Vice President W. Harold Parham, D.H.A.; Luis Perez, M.D., Sanford, Chairman, Committee on Allied Health Professions; John C. Fletcher, M.D., Tampa, Chairman, Council on Specialty Medicine.

3rd row: Gerold L. Schiebler, M.D., Gainesville, Editor of The Journal; James F. Richards, Jr., Orlando, Chairman, Council on Medical Economics; President-Elect Louls C. Murray, M.D., Orlando; AMA Delegate Rufus K. Broadaway, M.D., Miami; and Treasurer Richard S. Hodes, M.D., Tampa.

4th row: President Jack A. MacCris, M.D., St. Petersburg; Board Member J. Russell Forlaw, M.D., Boynton Beach; AMA Delegate Charles K. Donegan, M.D., St. Petersburg; Board Member Norman M. Kenyon, M.D., Miami; AMA Delegate Burns A. Dobbins, M.D., Ft. Lauderdale; and FMA Executive Director Donald C. Jones and Legal Counsel John Thrasher, both of Jacksonville.



Journ
Photos
John W. Glott



**COUNCIL ON
MEDICAL SERVICES**

**CARDIOPULMONARY
RESUSCITATION**

Approved establishment of a CME course on advanced life support training with each course being approved as hour-for-hour mandatory category credit for continuing medical education, and urged each component county medical society to sponsor such a course on a recurring and timely schedule, and requests that all county medical societies encourage their members to take advantage of such training.

**CRITICAL CARE
SURVEY**

Approved the recommendation that FMA work with the Florida Hospital Association and Department of HRS for the purpose of performing a joint survey on the critical care capabilities of Florida's hospitals.

**STATE DISASTER
PLAN**

Requested the Health Program Office, Department of HRS, to require that the state Disaster Plan Components relative to county medical plans (Health Annex Six) be submitted to the local county medical society, hospital association and EMS Advisory Committee for review and comment prior to submission to the state for approval, and requested that copies of any existing plans be immediately submitted to the aforementioned organizations for review.

**TRANSFER
AGREEMENTS**

Approved a position statement on transfer agreements: Any patient whose clinical needs exceed the capability of a facility or physician should be referred to a facility or physician who can provide optimal care for that patient. However, the decision to transfer any patient must be made solely by the responsible physician and with the consent of the receiving institution.

Approved FMA support of the statewide implementation of the 911 emergency phone system.

**HRS TREATMENT
OF PEDICULOSIS
AND SCABIES**

Notified the Department of Education and Health Program Office, Department of HRS, that the FMA supports the School Health Medical Advisory Committee's position with regard to treatment of pediculosis and scabies in that it is not necessary to exclude afflicted children from school after an effective application of pesticide

**SCHOOL HEALTH
SERVICES ACT**

and that the presence of nits after treatment is also, no cause for exclusion.

Expressed support for full state funding of the School Health Services Act of 1974.

RURAL HEALTH

Recognized as one acceptable approach to assisting rural medically underserved areas, the concept of utilizing primary care residents, with Florida license, as locum tenens for rural physicians on leave for illness, obtaining CME requirements or vacation.

**COMMITTEE ON
DRUG ABUSE**

Approved a request from the "Florida Association on Drug Abuse Treatment and Education Programs" that the FMA Committee on Drug Abuse serve as their Medical Advisory Committee.

Commended the Council on Medical Services, its Chairman, Russell Forlaw, M.D., and its Committees for outstanding work in areas of major importance to the Association.

**COUNCIL ON
LEGISLATION AND
REGULATIONS:**

Adopted the following positions regarding legislation to be considered by the 1977 session of the Florida Legislature:

Supported legislation that requires use of standard health claim forms by all insurers and the Department of HRS.

Endorsed HB 371 - Which would regulate diagnostic testing centers in Florida.

Opposed HB 349 - Which creates geriatric outpatient nurse clinics in conjunction with nursing homes. The bill requires these clinics to be managed and supervised by a geriatric nurse practitioner.

Opposed HB 547 - Provisions of bill set up Division of Consumer Advocacy within the Department of Community Affairs with duties to include "Assessment of the effectiveness of medical services currently available to the people of Florida."

Opposed SB 290, SB 291 - Creates functions for deputy assistant secretary for state health planning and development including a state health information system.

Opposed HB 222 - Which endorses

Kennedy-Corman concept for National Health Insurance.

Directed that the position of the FMA be "**Oppose**" on the following bills relating to chiropractic:

- A. Amendment to workmen's compensation law to allow patient choice of physician.
- B. Chiropractor shall be qualified as an expert witness within his area of licensure.
- C. Bill to prohibit insurance company from using M.D. testimony to demonstrate that a chiropractor's services were unnecessary.
- D. Bill to allow chiropractor to certify disability for purposes of property tax exemption.
- E. Bill to allow chiropractor to certify teacher is free from from malignant, communicable or mental diseases.
- F. Bill to require state employees group to provide chiropractic services. (HB 146)
- G. Bill to provide all health insurance contracts to provide chiropractic services (HB 376).

COUNCIL ON MEDICAL SYSTEMS

Directed that the request from H. Phillip Hampton, M.D., concerning the development of an ambulatory Health Care Information System be referred to the Florida Health Data Corporation, Inc.

Approved FMA support of Blue Shield's protest to CHAMPUS regarding individuals other than physicians performing medical peer review for psychiatric benefits under the CHAMPUS program. The FMA further reiterates the position of organized medicine that peer medical utilization review of physicians should only be performed by physicians.

PROVOCATIVE FOOD TESTING

GROUP HEALTH, INC.

PMUR

TELEPHONE DIRECTORY YELLOW PAGE LISTINGS

Directed that the report of the Dade County Medical Association Ad Hoc Committee on Provocative Food Testing be accepted.

Directed that the Bureau of Health Insurance be contacted and requested to instruct Group Health, Inc., to provide payment for M.D. Surgical Assistants, without harassment, in major surgical cases where assistance is usually needed.

Designated that an informational packet should be developed to distribute to county medical societies which explains in detail the Peer Review process.

Authorized the Committee on Peer Medical Utilization Review to take direct action and assume jurisdiction on cases not acted upon by the county medical societies within the time limits established by the peer medical utilization review operating procedures and the health insurance operating procedures.

Reaffirmed the Association's policy concerning telephone directory listings and issued the following statement concerning this policy:

"The FMA policy governing listing of members in telephone directories established basic ethical and professional standards for members who list in the yellow pages of the telephone directories. Additionally, it is the function of this policy to provide members of the public basic information in selecting a physician. However, this policy and the fact that a physician may or may not be listed under a specific specialty heading in no way reflects FMA endorsement or rejection of an individual physician's qualifications and/or training to practice within a particular specialty."

HEALTH CARE INFORMATION SYSTEM

CHAMPUS



BREATHING WITH COMFORT.

Choledyl — a highly soluble, true salt of theophylline — rapidly relaxes bronchospasm to promote easier breathing. And, gastric discomfort is minimal.

Because Choledyl is more stable...more rapidly absorbed from the G.I. tract than aminophylline.

Available in both tablets and elixir for patients with obstructive lung disease.

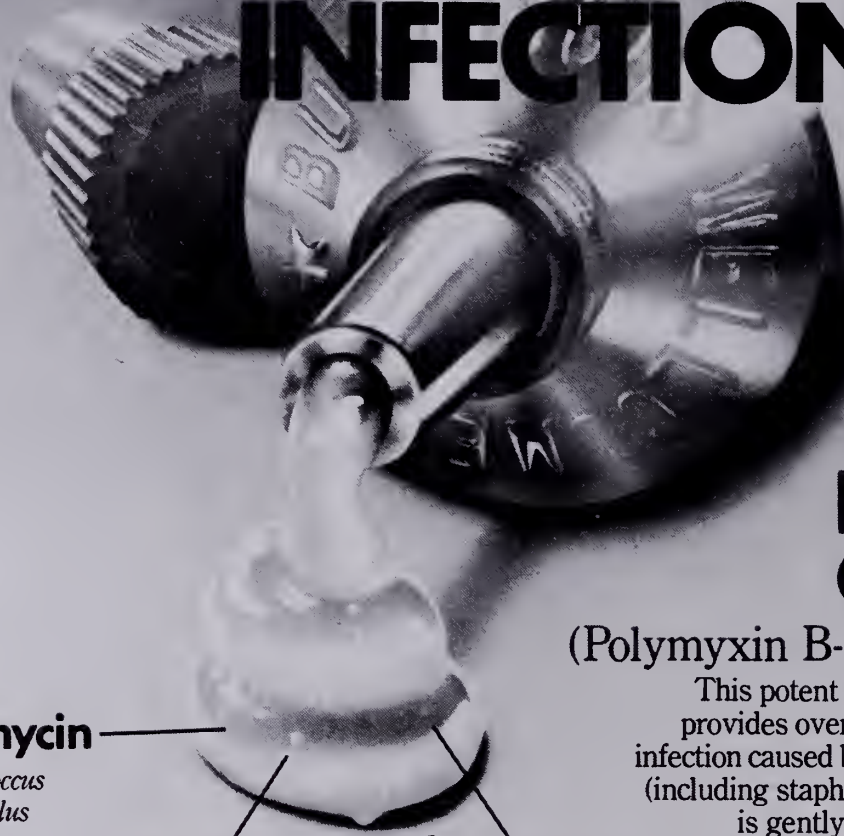
Choledyl® (oxtriphylline) Tablets and Elixir CAUTION: Federal law prohibits dispensing without prescription. Each partially enteric coated tablet contains 200 mg or 100 mg oxtriphylline. Each teaspoonful of the elixir contains 100 mg oxtriphylline; alcohol 20%. **Indications.** Choledyl (oxtriphylline) is indicated for relief of acute bronchial asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema. **Warning.** Use in pregnancy — animal studies revealed no evidence of teratogenic potential. Safety in human pregnancy has not been established; use during lactation or in patients who are or who may become pregnant requires that the potential benefits of the drug be weighed against its possible hazards to the mother and child. **Precautions.** Concurrent use of other xanthine-containing preparations may lead to adverse reactions, particularly CNS stimulation in children. **Adverse Reactions.** Gastric distress and, occasionally, palpitation and CNS stimulation have been reported. **Dosage.** Average adult dosage: Tablets — 200 mg, 4 times a day; Elixir — two teaspoonfuls, 4 times a day. **Supplied.** 200 mg yellow, partially enteric coated tablets in bottles of 100 (N 0047-0211-51) and 1000 (N 0047-0211-60); Unit Dose — 200 mg tablets (N 0047-0211-11); 100 mg red, partially-enteric coated tablets in bottles of 100 (N 0047-0210-51). Elixir — bottles of 16 fl oz (1 pint) 474 ml (N 0047-0215-16). **Toxicity.** Oxtriphylline, aminophylline and caffeine appear to be more toxic to newborn than to adult rats. No teratogenic effects have been seen. Full information is available on request.



WARNER/CHILCOTT
Division, Warner-Lambert Company
Morris Plains, N.J. 07950

CHOLEDYL® SINGLE-ENTITY
(OXTRIPHYLLINE) BRONCHODILATION
MINIMAL GASTRIC DISCOMFORT

THREE-IN-ONE THERAPY AGAINST TOPICAL INFECTION



Neosporin[®] Ointment

(Polymyxin B-Bacitracin-Neomycin)

This potent broad-spectrum antibacterial provides overlapping action to help combat infection caused by common susceptible pathogens (including staph and strep). The petrolatum base is gently occlusive, protective and enhances spreading.

Neomycin

Staphylococcus
Haemophilus
Klebsiella
Aerobacter
Escherichia
Proteus
Corynebacterium
Streptococcus
Pneumococcus

Bacitracin

Staphylococcus
Corynebacterium
Streptococcus
Pneumococcus

Polymyxin B

Pseudomonas
Haemophilus
Klebsiella
Aerobacter
Escherichia

In vitro overlapping antibacterial action of Neosporin[®] Ointment (polymyxin B-bacitracin-neomycin).



Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Neosporin[®] Ointment

(Polymyxin B-Bacitracin-Neomycin)

Each gram contains: Aerosporin[®] brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is

affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



DOCTORS ARE TALKING ABOUT THE PRACTICAL WAY TO LOWER CHOLESTEROL

Choloxin[®] (Sodium Dextrothyroxine)

And for good reasons. Diet alone doesn't always work. CHOLOXIN[®] (sodium dextrothyroxine) has proved itself to be an effective cholesterol lowering adjunct to diet in euthyroid, non-cardiac patients. It has undergone ten years of clinical trials and eight years of practice. The clinical trials consisted of 337 clinical studies involving over 3,000 hypercholesterolemic non-cardiac patients. It is among the most thoroughly evaluated drugs ever presented to physicians.

Practical, too, is the one-tablet-a-day dosage regimen. It encourages patient cooperation, and is economical for long-term therapy.

CHOLOXIN (sodium dextrothyroxine) lowers cholesterol 15% to 35%, and keeps it down with most patients. (*Data on file, Flint Laboratories*).

Interested in receiving more information about lipid lowering? Write us or contact your Flint representative. We'll be glad to supply you with a complete product portfolio and samples for your evaluation.

NOTE: See following page for full prescribing information.

AN IMPORTANT NOTE:

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.



FLINT LABORATORIES

DIVISION OF TRAVENOL LABORATORIES, INC.
Deerfield, Illinois 60015

Choloxin® (Sodium Dextrothyroxine)

Effectively Lowers Elevated Cholesterol With Convenient Once-A-Day Dosage

Four strengths, 1, 2, 4, and 6 mg are available making the scored tablet regimen a flexible dosage system. And, for most patients, CHOLOXIN tablets offer once-a-day dosage.

CHOLOXIN® (sodium dextrothyroxine) Single-Tablet-A-Day Dosage Schedules

See prescribing information in package insert reproduced below.

	Starting Dosage	Increased Monthly by	Usual Maintenance	Maximal Recommended
Adult Hypercholesterolemic	1.0-2.0 mg.	1.0-2.0 mg.	4.0-8.0 mg.	4.0-8.0 mg.
Pediatric Hypercholesterolemic	0.05 mg./kg. body weight	0.05 mg./kg.	0.1 mg./kg. body weight	4.0 mg.
Hypothyroid Cardiac	1.0 mg.	1.0 mg.	4.0 mg.	4.0 mg.

Choloxin® (Sodium Dextrothyroxine)

Description

CHOLOXIN (sodium dextrothyroxine) is the sodium salt of the dextrorotatory isomer of thyroxine. It is chemically described as D-3,5,3',5'-tetraiodothyronine sodium salt.

Actions

The predominant effect of CHOLOXIN (sodium dextrothyroxine) is the reduction of serum cholesterol levels in hyperlipidemic patients. Beta lipoprotein and triglyceride fractions may also be reduced from previously elevated levels.

Most of the available evidence indicates that CHOLOXIN (sodium dextrothyroxine) stimulates the liver to increase catabolism and excretion of cholesterol and its degradation products via the biliary route into the feces. Cholesterol synthesis is not inhibited and abnormal metabolic end-products do not accumulate in the blood.

Indications

This is not an innocuous drug. Strict attention should be paid to the indications and contraindications.

CHOLOXIN (sodium dextrothyroxine) is an antilipidemic agent used as an adjunct to diet and other measures for the reduction of elevated serum cholesterol (low density lipoproteins) in euthyroid patients with no known evidence of organic heart disease.

The drug is also indicated in the treatment of hypothyroidism in patients with cardiac disease who cannot tolerate other types of thyroid medication.

Before prescribing, note the following: Results from a randomized clinical study have indicated a possible adverse effect when CHOLOXIN (sodium dextrothyroxine) is administered to a patient receiving a digitalis preparation. There may be an additive effect. This additive effect may possibly stimulate the myocardium excessively, in patients with significant myocardial impairment. CHOLOXIN (sodium dextrothyroxine) dosage should not exceed 4 mg per day when the patient is receiving a digitalis preparation concomitantly. Careful monitoring of the total effect of both drugs is important.

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Contraindications

The administration of CHOLOXIN (sodium dextrothyroxine) to euthyroid patients with one or more of the following conditions is contraindicated:

1. Known organic heart disease, including angina pectoris; history of myocardial infarction; cardiac arrhythmia or tachycardia, either active or in patients with demonstrated propensity for arrhythmias; rheumatic heart disease; history of congestive heart failure; and decompensated or borderline compensated cardiac status.
2. Hypertensive states (other than mild, labile systolic hypertension).
3. Advanced liver or kidney disease.
4. Pregnancy.

5. Nursing mothers.

6. History of iodism.

Warnings

CHOLOXIN (sodium dextrothyroxine) may potentiate the effects of anticoagulants on prothrombin time. Reductions of anticoagulant dosage by as much as 30% have been required in some patients. Consequently, the dosage of anticoagulants should be reduced by one-third upon initiation of CHOLOXIN therapy and the dosage subsequently readjusted on the basis of prothrombin time. The prothrombin time of patients receiving anticoagulant therapy concomitantly with CHOLOXIN therapy should be observed as frequently as necessary, but at least weekly, during the first few weeks of treatment.

In the surgical patient, it is wise to consider withdrawal of the drug two weeks prior to surgery if the use of anticoagulants during surgery is contemplated.

When CHOLOXIN (sodium dextrothyroxine) is used as thyroid replacement therapy in hypothyroid patients with concomitant coronary artery disease (especially those with a history of angina pectoris or myocardial infarction) or other cardiac disease, treatment should be initiated with care. Special consideration of the dosage schedule of CHOLOXIN (sodium dextrothyroxine) is required. This drug may increase the oxygen requirements of the myocardium, especially at high dosage levels. Treated subjects with coronary artery disease must be seen at frequent intervals. If aggravation of angina or increased myocardial ischemia, cardiac failure, or clinically significant arrhythmia develops during the treatment of hypothyroid patients, the dosage should be reduced or the drug discontinued.

Special consideration must be given to the dosage of other thyroid medications used concomitantly with CHOLOXIN (sodium dextrothyroxine). As with all thyroid drugs, hypothyroid patients are more sensitive to a given dose of CHOLOXIN (sodium dextrothyroxine) than euthyroid patients.

Epinephrine injection in patients with coronary artery disease may precipitate an episode of coronary insufficiency. This condition may be enhanced in patients receiving thyroid analogues. These phenomena should be kept in mind when catecholamine injections are required in sodium dextrothyroxine-treated patients with coronary artery disease.

Since the possibility of precipitating cardiac arrhythmias during surgery may be greater in patients treated with thyroid hormones, it may be wise to discontinue CHOLOXIN (sodium dextrothyroxine) in euthyroid patients at least two weeks prior to an elective operation. During emergency surgery in euthyroid patients, and in surgery in hypothyroid patients in whom it may not be advisable or possible to withdraw therapy, the patients should be carefully observed.

There are reports that sodium dextrothyroxine in diabetic patients is capable of increasing blood sugar levels with a resultant increase in requirements of insulin or oral hypoglycemic agents. Special attention should be paid to parameters necessary for good control of the diabetic state in dextrothyroxine-treated subjects and to dosage requirements of insulin or other antidiabetic drugs. If sodium dextrothyroxine is later withdrawn from

patients who had required an increase of insulin (or oral hypoglycemic agents) dosage during its administration, the dosage of antidiabetic drugs should be reduced and adjusted to maintain good control of the diabetic state.

When either or both impaired liver or kidney function are present, the advantages of CHOLOXIN (sodium dextrothyroxine) therapy must be weighed against the possibility of deleterious results.

Usage in Women of Childbearing Age

Women of childbearing age with familial hypercholesterolemia or hyperlipemia should not be deprived of the use of this drug; it can be given to those patients exercising strict birth control procedures. Since pregnancy may occur despite the use of birth control procedures, administration of CHOLOXIN (sodium dextrothyroxine) to women of this age group should be undertaken only after weighing the possible risk to the fetus against the possible benefits to the mother. Teratogenic studies in two animal species have resulted in no abnormalities in the offspring.

Precautions

It is expected that patients on dextrothyroxine therapy will show greatly increased serum protein-bound-iodine levels. These increased serum PBI values are evidence of absorption and transport of the drug, and should NOT be interpreted as evidence of hypermetabolism; similarly, they may not be used for titrating the effective dose of CHOLOXIN (sodium dextrothyroxine). PBI values in the range of 10 to 25 mcg% in treated patients are common. If signs or symptoms of iodism develop during CHOLOXIN (sodium dextrothyroxine) therapy, the drug should be discontinued.

A few children with familial hypercholesterolemia have been treated with CHOLOXIN for periods of one year or longer with no adverse effects on growth. However, it is recommended that the drug be continued in patients in this age group only if a significant serum cholesterol-lowering effect is observed.

Adverse Reactions

The side effects attributed to dextrothyroxine therapy are, for the most part, due to increased metabolism, and may be minimized by following the recommended dosage schedule. Adverse effects are least commonly seen in euthyroid patients with no signs or symptoms of organic heart disease; the incidence of adverse effects is increased in hypothyroid patients, and is highest in those patients with organic heart disease superimposed on the hypothyroid state.

In the absence of known organic heart disease, some cardiac changes may be precipitated during sodium dextrothyroxine therapy. In addition to angina pectoris, arrhythmia consisting of extrasystoles, ectopic beats, or supraventricular tachycardia, ECG evidence of ischemic myocardial changes and increase in heart size have been observed. Myocardial infarctions, both fatal and non-fatal, have occurred, but these are not unexpected in untreated patients in the age groups studied. It is not known whether any of these infarcts were drug related.

Changes in clinical status that may be related to the metabolic action of the drug include the development of insomnia, nervousness, palpitations, tremors, loss of weight, lid lag, sweating, flushing, hyperthermia, hair loss, diuresis, and menstrual irregularities. Gas-

trointestinal complaints during therapy have included dyspepsia, nausea and vomiting, constipation, diarrhea, and decrease in appetite.

Other side effects reported to be associated with CHOLOXIN (sodium dextrothyroxine) therapy include the development of headache, changes in libido (increase or decrease), hoarseness, tinnitus, dizziness, peripheral edema, malaise, tiredness, visual disturbances, psychic changes, paresthesia, muscle pain, and various bizarre subjective complaints. Skin rashes, including a few which appeared to be due to iodism, and itching have been attributed to dextrothyroxine by some investigators. Gallstones have been discovered in occasional dextrothyroxine-treated patients and cholestatic jaundice has occurred in one patient, although its relationship to CHOLOXIN therapy was not established.

In several instances, the previously existing conditions of the patient appeared to continue or progress during the administration of CHOLOXIN (sodium dextrothyroxine); a worsening of peripheral vascular disease, sensory, exophthalmos, and retinopathy have been reported.

CHOLOXIN (sodium dextrothyroxine) potentiates the effects of anticoagulants, such as warfarin or Dicumarol, on prothrombin time, thus indicating a decrease in the dosage requirements of the anticoagulants. On the other hand, dosage requirements of antidiabetic drugs have been reported to be increased during dextrothyroxine therapy (see WARNINGS section).

Dosage and Administration

For adult euthyroid hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is 4 to 8 mg per day. The initial daily dose should be 1 to 2 mg to be increased in 1 to 2 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, if that dosage level is indicated to effect the desired lowering of serum cholesterol.

When used as partial or complete substitution therapy for levothyroxine in hypothyroid patients with cardiac disease who cannot tolerate other types of thyroid medication, the initial daily dose should be 1 mg to be increased in 1 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, preferably the lower dosage. The maximum in patients receiving digitalis therapy is 4 mg.

For pediatric hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is approximately 0.1 mg (100 mcg) per kilogram. The initial daily dosage should be approximately 0.05 mg (50 mcg) per kilogram to be increased in up to 0.05 mg (50 mcg) per kilogram increments at monthly intervals. The recommended maximal dose is 4 mg daily, if that dosage is indicated to effect the desired lowering of serum cholesterol.

If new signs or symptoms of cardiac disease develop during the treatment period, the drug should be withdrawn.

How Supplied

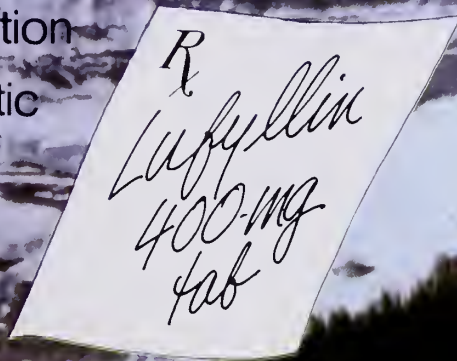
CHOLOXIN (sodium dextrothyroxine) is supplied in prescription packages of scored 1, 2, 4, and 6 mg tablets.

"AIR...A BASIC NEED FOR LIFE SUPPORT"

LUFYLLIN[®]-400 (dyphylline, 400-mg tablets)

A basic need for the bronchospastic patient because...

- A single-entity theophylline derivative
- Therapeutically effective
- High solubility for predictable absorption
- Doses required to achieve therapeutic levels are readily tolerated with little to no gastric distress.



LUFYLLIN[®] (dyphylline)
LUFYLLIN[®]-400 (dyphylline) Tablets

Following is a Brief Summary:

Indications: For relief of acute bronchial asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema.

Contraindications: In individuals who have shown hypersensitivity to any of its components.

Dyphylline should not be administered concurrently with other xanthine preparations.

Precautions: Use with caution in patients with severe cardiac disease, hypertension, hyperthyroidism, or acute myocardial injury. Particular caution in dose administration must be exercised in patients with peptic ulcers, since the condition may be exacerbated. Chronic oral administration in high doses (500 to 1,000 mg) is usually associated with gastrointestinal irritation.

Great caution should be used in giving dyphylline to patients in congestive heart failure. Such patients have shown markedly prolonged blood level curves which have persisted for long periods following discontinuation of the drug.

Adverse Reactions: Note: Included in this listing which follows are a few adverse reactions which may not have been reported with this specific drug. However, pharmacological similarities among the xanthine drugs require that each of the reactions be considered when dyphylline is administered.

The most consistent adverse reactions are:

1. Gastrointestinal irritation: nausea, vomiting, and epigastric pain, generally preceded by headache, hematemesis, diarrhea.

2. Central nervous system stimulation: irritability, restlessness, insomnia, reflex hyperexcitability, muscle twitching, clonic and tonic generalized convulsions, agitation.

3. Cardiovascular: palpitation, tachycardia, extrasystoles, flushing, marked hypotension, and circulatory failure.

4. Respiratory: tachypnea, respiratory arrest.

5. Renal: albuminuria, increased excretion of renal tubule and red blood cells.

6. Others: fever, dehydration.

Dosage and Administration: Adults—Usual Dose—15 mg/kg every 6 hours, up to four times a day. The dosage should be individualized by titration to the condition and response of the patient, with therapeutic blood levels considered to be between 10 mcg/ml and 20 mcg/ml. Levels above 20 mcg/ml may produce toxic effects.

How Supplied:

LUFYLLIN[®] Tablets—containing 200 mg dyphylline, NDC 0019-R521-92, bottles of 100; NDC 0019-R521-97, bottles of 1000.

LUFYLLIN[®]-400 Tablets—containing 400 mg dyphylline, NDC 0019-0731-92, bottles of 100.

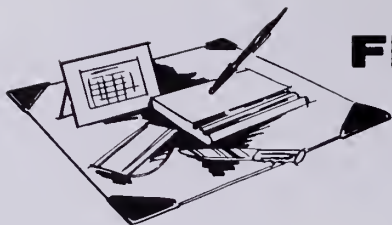
CAUTION: Federal (U.S.A.) law prohibits dispensing without prescription.

For full prescribing information, please review package insert, or write

Mallinckrodt

Pharmaceuticals Linking Chemistry to Medicine

Mallinckrodt, Inc. St. Louis, Mo. 63134



FROM THE EDITOR'S DESK

LEGAL DEFENSE

The AMA is contributing \$15,000 to the legal defense of Quenton Young, M.D., who was dismissed without hearing as Chairman of the Department of Medicine at Chicago's Cook County Hospital. Dr. Young was accused of helping organize a house staff strike in 1975. A federal judge held that his dismissal was in violation of due process. He was dismissed again after a hearing, but again the court cited violation of due process. The hospital is appealing the federal court ruling.

* * * *

FRAUD

The Illinois State Medical Society has charged that confidential patient records are being obtained fraudulently in the Chicago area for use in damage suits. ISMS said some attorneys are suspected of forging patient authorization forms for release of medical records, paying hospital employees to identify cases for potential lawsuits and encouraging patients to sue.

* * * *

VIDEO VIOLENCE

Five large corporations have announced they will review their advertising policies concerning sponsorship of violent primetime television programs. They are Sears, General Motors, Schlitz, Kraft and Samsonite. Union Oil reportedly has told its ad agency not to buy time on violent programs.

* * * *

TRADE RESTRAINT

Trial date for the Federal Trade Commission's restraint of trade complaint has been moved back from June 7 to September 7. The complaint, concerning advertising by physicians and medical ethics, was filed more than a year ago.

* * * *

AMPAC MEMBERSHIP

The American Medical Political Action Committee (AMPAC) reports that so far, 1977 membership is running ahead of the record set in 1976. Meanwhile, AMPAC reported that it supported 390 candidates in the 1976 elections, and almost three of every four won their races.

* * * *

AMA HIGH IN POLL

The AMA is publicizing a recent Gallup Poll which shows that it, the AMA, ranks high in public credibility. AMA had a rating of 6.8 on a ten-point scale, compared with an average of 6.5 for professional associations in general; 5.1 for trade associations; 5.7 for government agencies; and 5.4 for labor unions.

* * * *

MALPRACTICE SUITS

1976 professional malpractice suit statistics from Chicago show an interesting turn of events. The number of such suits against physicians and hospitals fell to 761 last year, from the 1,099 recorded the year before. At the same time, malpractice suits against lawyers more than doubled, to 95.

* * * *

MILITARY MEDICAL SCHOOL

The nation's new military medical school near Washington, now in its first year of operation, is to be closed. Secretary of Defense Harold Brown said the military's physician manpower needs can be satisfied more economically by direct recruitment. Unless Congress overrides the Administration, the current 32 students will be placed elsewhere in scholarship programs and the facilities will be put to other use.

* * * *

FOOD AND NUTRITION

AMA has called upon the U.S. Senate to continue the Senate Select Committee on Nutrition and Human Needs. The AMA expressed concern about the continued emphasis "on these important aspects of the nation's health" if a proposal to merge the Committee with the Senate Agriculture Committee is carried out.

* * * *

JCAH STANDARDS

Physicians employed by hospitals in medico-administrative positions may be dismissed without a hearing under a revised standard adopted by the Joint Commission on Accreditation of Hospitals. However, the matter of staff privileges will be subject to due process before the medical staff.

* * * *

CATASTROPHIC MEDICAL COSTS

Financing of catastrophic medical costs "does not appear to be a serious national problem for the 103 million persons estimated to be covered by major medical insurance," according to the Congressional Budget Office. But the agency said "serious coverage problems" exist for both routine and catastrophic expenses incurred by low-income families.

* * * *

TV VIOLENCE

AMA Trustee Frank J. Jirka, M.D., has stated that scientific evidence points to a relationship between video violence and aggressive behavior in some youthful viewers. Dr. Jirka testified at one of a series of public hearings being sponsored throughout the country by the Parent-Teachers Association.

* * * *

HELP FOR CITIES

The Robert Wood Johnson Foundation is granting \$15 million to help up to five cities upgrade services in neighborhoods where emergency rooms and outpatient clinics provide most of the care. Recipients of the grants will be selected from among the 50 largest cities in the nation.

The Editor



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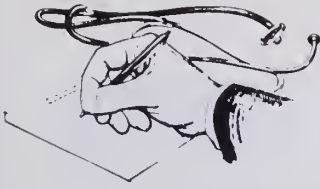
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Others Are Saying

A Statement from Dr. Brasfield

(EDITORS NOTE: The following is a statement made by Dr. Stan Brasfield after the dismissal of the malpractice suit against him. The case against Brasfield was dismissed in federal court after a two-year period of litigations and numerous newspaper articles in the local and state press:)

"Up until this time, I have been advised by my attorneys to refrain from making any statements concerning the lawsuit pending against me. This was difficult to do because of the repeated newspaper articles that appeared in the local press restating the misleading and malicious statements that were contained in the plaintiff's lawsuit.

"I realize that the press was simply quoting allegations made by the people who brought the suit against me but as is so often true, the repetition of a falsehood is often accepted by those who read it as being true. I have learned a great deal about the law in the past two and a half years and much of it is unfair.

"The first I knew about Dawn Gordon, the little girl involved in this lawsuit, having substantial brain damage as a result of spinal meningitis was by a call from her attorneys almost two years after the time I saw her on a Saturday evening at Russell Hospital.

"Since the law places the burden on the plaintiff to prove that a doctor either negligently or willfully caused a patient's damage, then it is inappropriate for the court record prior to trial to show the doctor's contentions. With the appearance of each news article, I wanted my lawyers to state what I did and how I did it to the press, but I realized they were right in saying that the case should be tried in court and not in the newspapers.

"Now that the case is over, I want to answer the complaint. For a fee of \$7, I saw this child with an elevated temperature and an infected ear.

"I only saw this child that one day as her parents desired to take her back to Florida for hospitalization and diagnosis. I did not know that they took her to Montgomery and as a result of tests in the hospital and confirmed later by the University Hospital in Birmingham discovered that she

suffered from a rare type of meningitis.

"The hospital records here in Alex City confirm my desire to hospitalize the child for extensive tests and at the request of her parents, I did not do so and they left me with the understanding that they were on their way back to their home in Florida.

"No pediatrician who is worthy to be called "doctor" would have administered massive doses of medication without prior appropriate testing.

"Alexander City is a small town. There was no 600 man medical community in which I could hide. In the weeks that followed the release of this news about the two million dollar malpractice suit, I received telephone calls and letters from patients, other physicians and other people who offered prayers, support and comfort.

"The people of this area were great and continued to support me for which I will be eternally grateful. My children were confronted by their peers with questions and accusations. This was natural since most children tend to believe everything they read or hear.

"It was difficult to explain to our children why they could not fight every child who accused their father. As time passed, the case was continued six times and another physician was added to the suit.

"There was no indepth investigation reporting by the media to show that at one point there was a time gap of 118 days between the time that my jury was struck and the time of the trial.

"There was no indignant call for a speedy trial to bring about justice for the child or for me — there was only the repetition of the charges made one and one half years earlier. There are many doctors who must endure hardships and harrassments of a malpractice suit and only the small percentage of one out of every six who are sued are found guilty.

"These facts are rarely reported. I believe that this is negligent and an abuse of the right of a free press. Everyone makes mistakes; physicians make them and admit them; lawyers make them and admit them. The press makes them and sometimes admit them on the bottom of page 32.

"The fact that the parents of this child dismissed their suit against me is conclusive proof that I was not guilty of negligent treatment of their child in any manner. However, this cannot erase the many months of suffering that my family endured because of these false accusations.

"I incurred extensive legal fees as well as long periods of absence from my office in successfully defending these false claims and preparing my defense. There is no way to recoup these losses.

"My inclination is to file a counter-suit and to put these people through the same harassment and hurt that I suffered; however, time is a great healer and I hope that I can be as forgiving and understanding of them as the people in Alex City have been to me.

"There must be an improvement in the judicial system that permits unfounded claims and lawsuits against doctors. We are not God.

"As I close the book on this chapter of my life, I am comforted by the fact that the judicial system with all of its errors has demonstrated that no negligence on my part was proven because I in fact did what a careful and prudent pediatrician would have done under the same circumstances."

Reprinted from the ALEXANDER CITY OUTLOOK, Wednesday, December 15, 1976. Sent to us for reprinting by Dr. Samuel M. Day, Jacksonville.

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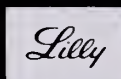
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Hypersensitivity to the Imported Fire Ant in Florida

Report of 104 Cases

Robert B. Rhoades, M.D., Walter L. Schafer, M.D., M. Newman, M.D., R. Lockey, M.D.,
Richard M. Dozler, M.D., Paul F. Wubben, M.D., Andrew W. Townes, M.D., William H. Schmid, M.D.,
G. Neder, M.D., T. Brill, M.D., and Heinz J. Wittig, M.D.

ABSTRACT: Two South American species of the fire ant group, *Solenopsis richteri* and *Solenopsis invicta*, now occupy more than 150 million acres in the southern United States and cause systemic allergic reactions to their stings. We report 104 cases (including 49 previously reported) of such reactions with case reports and documentation. Specificity of the sting was documented by either typical pustule formation or positive skin tests. Of 92 patients treated with hyposensitizing injections, 19 have subsequently been restung. Only two suffered systemic reaction. Problems of cross-reactivity with other insects are discussed and the literature is reviewed. Hypersensitivity to the imported fire ant continues to be a serious problem in the southern United States and appears to be amenable to properly instituted hyposensitization therapy.

The prevalence and importance of allergic reactions to the sting of the imported fire ant (IFA) are grossly underrated. Prior to our first report,¹ a review of the literature revealed only 37 cases of presumed fire ant hypersensitivity of which only 25 were well documented. Of 18 patients in these

reports who had been treated by hyposensitizing injection therapy, eight were restung; and none suffered any systemic effects from this reexposure.²

We previously reported data on 49 cases.¹ This report incorporates an additional 54 cases plus an analysis of the incidence of IFA sensitivity in selected areas of Florida and results of hyposensitization therapy. Our conclusions are based on the experience of 11 practicing allergists in the state of Florida.

Background

Two South American species of the fire ant group, *Solenopsis richteri* and *Solenopsis invicta* (Fig. 1), were introduced into the United States during the first half of this century by way of Mobile, Alabama.³ The *invicta* species now is found in more than 150 million acres of land in the southern United States (Fig. 2) and can cause systemic allergic reactions as a result of its sting. There are also two native species of the fire ant group, *Solenopsis geminata* and *Solenopsis xyloni*, which, however, are not aggressive and generally do not represent a significant hazard to man or animal. The imported fire ant is much more prolific than its domestic cousins and is characterized by exceptional aggressiveness. Sporadic attempts at controlling this insect have been unsuccessful. The imported fire ant accounts for many human bites. Clinical hypersensitivity is common.

Although the terms "bite" and "sting" have been

From the Department of Pediatrics (Dr. Rhoades and Dr. Wittig), University of Florida College of Medicine, Gainesville, and from practicing allergists in Gainesville (Dr. Brill), St Petersburg (Dr. Schafer and Dr. Schmid), Jacksonville (Dr. Wubben and Dr. Newman), Tallahassee (Dr. Dozier), Orlando (Dr. Townes and Dr. Neder), and Tampa (Dr. Lockey).

This work has been supported in part by the National Institutes of Health grant T 01-A100341.



Fig. 1. — Scanning electron photomicrograph of worker imported fire ant.

used interchangeably, the attack mechanism of this ant should be mentioned. The imported fire ant does indeed bite with its jaws, but this is primarily for the purpose of securing itself to the victim. It then proceeds to pivot about the head, stinging at multiple sites in a circular distribution with its abdominal stinger which is a modified ovapositor with associated venom gland.

The sting of the imported fire ant produces a sterile pustule within 24 hours (Fig. 3). This is a very significant diagnostic finding since, for practical purposes, the fire ant is the only insect in the United States whose sting produces a pustule of this type. The pathophysiology of this pustule formation is well documented by Caro et al.⁴ The absence of a pustule does not, however, exclude the possibility of a sting of the imported fire ant.⁵ Pustules are occasionally caused by the sting of the domestic species.^{5,6}

Clinical Material and Methods

1. Patient Selection: All patients included in this report fulfilled the following criteria:

a. History of a reaction of the immediate type involving a part of the body distant from the site of the sting. Patients with exaggerated local reactions only, even those with swellings across neighboring joints, were excluded from this report. Patients with systemic reactions to unspecified ants in which documentation of fire ant involvement could be accomplished were also excluded.

b. Either pustule formation at the sting site or a positive skin test for imported fire ant, or both, as presumptive evidence of specificity for imported fire ant (see discussion). Six of the cases were further confirmed by identification of the offending ants as *S. invicta* by an ant taxonomist.

2. Clinical Data

a. Diagnostic Methods: There was some variation in skin test procedures among the 11 allergists participating in this study. Results are recorded in Table 1, representing the positive end point of skin testing. All testing materials were from Greer Laboratories, Inc., of Lenoir, North Carolina.

b. Signs and Symptoms: The most prominent were urticaria and/or angioedema followed by gastrointestinal, respiratory, and cardiovascular symptoms. These are shown in Table 2.

c. **Treatment:** Hyposensitization therapy was accomplished in varying dosage schedules with aqueous extracts from Greer Laboratories. All schedules included maintenance doses at a minimum of monthly intervals between injections.

Immediate treatment of sting reactions included antihistamines, steroids, catecholamines and general supportive measures. The case reports elaborate on this type of treatment.

d. **Incidence Data:** Patients whose initial visit to the participating allergists was between November 1, 1973 and October 31, 1974 were analyzed separately in order to determine the frequency of the problem. The city of Jacksonville, Florida, was chosen as the prime area for analysis because: (1) the area is served almost entirely by two allergists, both of whom participated in the study; (2) Jacksonville is a large population center isolated by a basically rural surrounding area with no competing center containing an allergist within an 80-mile radius; (3) based on observations of the entomologist, the fire ant infestation can be considered moderate and representative of many other areas in the state. A second area chosen for analysis was the Tampa-St. Petersburg area since this represents an area of heavy infestation. A limited study was also done to estimate the incidence rate over the last three years in certain

selected allergy practices which are fairly stable to get an idea whether there was any trend in the incidence of the fire ant hypersensitivity. The patient charts of one busy practice were analyzed and a comparison made of the incidence of other stinging hymenoptera sensitivity to the incidence of fire ant sensitivity.

TABLE 1.
FA HYPERSENSITIVITY SKIN TEST RESULTS (86 Patients).

To Fire Ant	Scratch	ID
1:10,000,000		5
1:1,000,000	1	6
1:100,000	1	12
1:10,000	3	15*
1:1,000	2	15**
1:100	6	1
1:20	15	

Negative Skin Test: 4 patients

Other Stinging Hymenoptera: wasp, yellow jacket, bee, hornet, and red ant: Positive; 17/39

*or 100 PNU

**or 1,000 PNU



Fig. 2. — Distribution of Imported fire ant.

TABLE 2. — FA HYPERSENSITIVITY SIGNS AND SYMPTOMS.

	Number	Percent
Skin:		
Generalized urticaria	80	77
Generalized angioedema	70	67
Respiratory:		
Tightness in chest	17	16
Difficulty breathing	30	29
Wheezing	14	14
Cough	10	10
"Could not talk"	5	5
Chest pain	11	11
Hoarseness	6	6
Laryngeal edema	1	1
GI:		
Nausea	11	11
Vomiting	5	5
Abdominal pain	6	6
Dysphagia	7	7
Swollen throat or tongue	3	3
Itching throat	1	1
Choking	3	3
Cardiovascular:		
Fall in blood pressure	11	10
Collapse	13	12
Dizziness	20	19
Sweating	10	10
Cyanosis	3	3
Vasoconstriction or vasodilation	6	6
Tachycardia and palpitations	2	2
Neurologic:		
Unconsciousness	11	11
Convulsions	3	3
Blurred vision	2	2
Confusion	1	1
Drowsiness	2	2
General:		
Malaise	1	1
Fever	2	2
Head throbbing	1	1
Weakness	3	3
Leg pains	1	1
Generalized pruritis	13	12
Numbness	1	1

Results

As seen in Table 3, eight patients had associated hypersensitivity reactions to other insects. Reactions included one mild to moderate generalized reaction to Deer Fly, one severe systemic reaction to the Saddleback Caterpillar, one severe reaction to spider bite; five patients had systemic reactions to bee, hornet or wasp stings. The patients with stinging hymenoptera sensitivity were also treated with aqueous extract of mixed stinging insects.

The highest estimated number of stings was 100, so that the possibility of systemic reactions on the basis of venom toxicity could be eliminated. Other authors have noted the occurrence of hundreds of stings in nonsensitive subjects without systemic symptoms.^{7,14} The time of onset of symptoms after the sting ranged from 1 to 60 minutes, thus excluding cases of delayed hypersensitivity reactions. The presence or absence of pustules was documented in 69% of our patients. Of these 86% had pustules. All other patients had positive skin test reactions to aqueous extracts of the imported fire ant.

There were four instances of systemic reactions from skin testing. One man reported moderate substernal pain following scratch testing, and one

TABLE 3. — FA HYPERSENSITIVITY HISTORY.

	Number	Percent
Number of Patients	104	100
Male	52/104	50
Female	52/104	50
Age (range 1-72 years)	23 yrs.*	
Children (0-18 years)	44/104	42
Time of Onset of Symptoms (range 1-60 min.)	13 min.*	
Number of Bites (range 1-100)	10*	
History of Allergy	28/83	34
History of Other Insect Sensitivity	8/104	7
History of Systemic Reaction to Previous Ant Bites	19/104	18
Pustules Present at 24 Hours	62/72	86
Pustules Not Present at 24 Hours	10/72	14

*Average



Fig. 3. — Pustule on forearm of individual stung by the imported fire ant.

child experienced generalized urticaria within 15 minutes after a positive scratch test. A third man developed itching of the armpit within 10 minutes of intradermal skin test on that arm, and a fourth man developed hives and pruritis shortly after skin testing.

As seen in Table 4, 92 of 104 patients were subjected to hyposensitizing injection therapy. Of 19 patients restung after beginning therapy, only two had constitutional reactions. All other patients had only local reactions. Hyposensitization schedules varied but all of them began with weekly injections at the approximate level of sensitivity shown on the skin testing. Most of the patients in Table 4 were restung while on maintenance therapy, which was generally in the range of weekly injections at .5 cc of a 1 to 10 or a 1 to 50 weight-volume dilution of whole body fire ant extract. Clearly, a number of individuals were protected by much lower concentrations. However, in view of the variability of response, it is somewhat tenuous to speculate about levels of protection. About half the patients had been restung on more than one occasion.

Incidence Data

An analysis of the patient charts from an allergist in Jacksonville revealed 772 new patient workups during the period from November 1, 1973 through October 31, 1974 (Table 5). Of these there were 15 cases of systemic allergic reactions to stinging hymenoptera, including bees, wasps, hornets, yellow jackets, etc., as compared to 18 cases of systemic allergic reactions to fire ant stings.

The Jacksonville practice is a busy one with a large number of new patients, a significant percentage of self-referred patients, and no other known bias concerning types of patients seen.

During a similar time period patients seen by an allergist in the Tampa area were tabulated. There is some bias involved in that he is known to be interested in insect hypersensitivity, particularly fire ant sting allergy. His practice is smaller than the first and has a significantly higher proportion of hymenoptera-sensitive patients. During this period 25 patients with systemic allergic reactions to hymenoptera stings were seen; 15 reactions were to

TABLE 4. — RESULTS OF HYPOSENSITIZATION THERAPY.

Patient	Age	Sex	Duration of Treatment at time of Resting*	Type of Reaction
1. WS	11	M	8 months	Local
2. PR	26	M	7 months	Local
3. DD	7	F	Off treatment one year	Local
4. AB	9	M	6 months	General
5. ND	42	F	3 months	Local
6. JB	33	M	6-18 months (stung on several occasions)	(See discussion)
7. KM	27	F	1 year (restung 4 times)	Local (Case 1)
8. JB	2	M	2 years (multiple restings)	Local
9. JF	14	M	4 months (restung 3 times)	Local
10. WB	50	M	6 months (multiple restings)	Local
11. CH	3	M	4 months (1 episode; 4 bites)	Local
12. BT	30	F	1 month (1 bite on 2 occasions)	Local
13. SP	26	F	4 months (1 bite)	Local
14. JB	2½	M	3-4 years (restung several times)	Local
15. DP	3	M	4 months (2 bites)	Local
16. MR	38	M	1-2 months (restung 2 times)	Local
18. ML	3	M	2 months	Local
19. IM	46	F	8 months	Local

Number of Patients Treated: 92/104

Number of Patients Restung after Therapy: 19/92

Number of Systemic Reactions while on Therapy: 2/19

*All patients were treated with aqueous extracts obtained from Greer Laboratories, Inc., Lenior, North Carolina.

**TABLE 5. — INCIDENCE OF SYSTEMIC ALLERGIC REACTIONS TO
IMPORTED FIRE ANT (New Cases).**

1. Incidence in allergy practice* of imported fire ant and other hymenoptera sensitivity:

a. Jacksonville, Florida (11/1/73 - 10/31/74):	
Total new patients	722
Imported fire ant sensitive patients	18
Other hymenoptera sensitive patients	15
b. Tampa, Florida:	
Total new patients	500
Imported fire ant sensitive patients	15
Other hymenoptera sensitive patients	10

II. Incidence of new imported fire ant sensitivity cases over time in stable practice:

	Prior to 1972	10/72 - 10/73	11/73 - 10/74
a. St. Petersburg, Florida:	5	7	8
b. Tallahassee, Florida:	7	6	3

III. Minimal incidence per population area served:

- a. **Jacksonville:** 21 cases/year = 3.8/100,000/year

*All practices are of full-time allergists.

the imported fire ant, one to red ants, and the remaining nine to bees and wasps.

The data from six allergist throughout the state were collected for the entire period prior to October 1973 by way of a retrospective record search. A number of the members of this group had had the same practice for more than five years and one of them for over 15 years. Collective data for these years elicited 49 fire ant sensitivity cases. Cases recorded between November 1, 1973 and October 31, 1974 included two new major contributors who between them accounted for 30 patients. A total of 55 cases were documented during this one-year period. Even if one subtracts the two new contributors (whose records predating November 1973 were not analyzed), there are 25 cases from the original contributors in **one year** as compared to twice that number in the remainder of their practice experience.

An analysis of two fairly stable, long-term practices was made to look at this trend (Table 5).

A third analysis was made in an attempt to get minimal incidence figures. These figures represent minimal incidence of well documented cases because not all the affected patients are seen by allergists and because we have no data from other physicians who are part-time allergists and as such might see a small number of these patients. The number of new cases during the year ending October 31, 1974 in metropolitan Jacksonville was

21. The population of the area is approximately 560,000; this gives an incidence of 3.8 per 100,000 per year. These figures only begin to scratch the surface when one considers not only the patients seen in emergency rooms but also those who are never diagnosed and those who present as sudden unexplained deaths.

Case Reports

Case 1: K. M., a 27-year-old woman without previous allergic history, was bitten on August 18, 1972 by two ants on her right great toe. This produced local burning and itching progressing in a matter of a few minutes to urticaria, dyspnea, chest pain, and general pruritis. When this increased over the next half hour to severe dyspnea with dizziness she was admitted to the emergency room and diagnosed as being in anaphylactic shock with diminished blood pressure and unconsciousness. This condition responded to intravenous treatment with adrenalin, steroids, and supportive measures. Two weeks prior to this episode she had received five bites which produced nausea and vertigo and a local reaction only. She had a 3+ intradermal skin test with 1 to 10 million dilution of Greer fire ant extract and a 2+ reaction to 1 to 1 million dilution of mixed stinging insects. She had no previous history of stinging insect sensitivity. Treatment was begun in August 1972 with aqueous fire ant extract. She had subsequently been restung on four occasions

between August 2, 1973 and September 3, 1973 (twice with pustule formation) with no systemic symptoms.

Case 2: P. B. is a 31-year-old nonatopic male, a lifelong resident of Canada who had never been out of that country prior to 1972 when he visited Florida. While working under his car at the side of the road he sustained approximately 15 ant bites which produced pustules (within 24 hours). Within a few minutes generalized urticaria, angioedema and wheezing developed followed by collapse. He was cyanotic and unconscious on arrival at the emergency room in St. Petersburg. He responded to epinephrine, intravenous steroids, oxygen, and Benadryl. He subsequently related that he had no known insect sensitivity and no previous ant bite reaction. He returned to Canada shortly after that without having been skin tested or treated. This case clearly could not have been the result of previous fire ant sensitization, and the sensitizing agent must have been some other insect with shared antigens.

Discussion

Dr. Triplett, in an unpublished survey, sent questionnaires to 2,485 doctors in 143 counties in Mississippi, Georgia, and Alabama which were heavily infested by imported ants. He received replies from 1,036 doctors who reported from 9,422 patients in 1969 to 11,937 in 1970 to 12,438 in 1971, who were treated for fire ant stings and complications. This survey was striking in not only its impressive trend in increasing incidences over the three-year period but also in the high number of reported secondary infections, debridements, skin grafting, and a total of 16 cases of amputation. Of the total number of patients treated, approximately 10% (1,356 in 1971) were reported to have urticaria and angioedema; about half of these had other more serious signs of systemic involvement. In all, 147 cases of anaphylactic shock were reported and a total of 17 deaths. His estimated cost of medical care for these patients was over \$350,000 for the year 1971 alone.

The rationale of hyposensitization therapy for fire ant prior to Dr. Triplett's report² in the spring of 1973 was based simply on faith and an extrapolation from the data obtained in stinging hymenoptera hyposensitization treatment. Although this extrapolation had no valid basis, it appears that such treatment may be effective based on the limited data now available. In Dr. Triplett's series, eight of 18 patients on hyposensitization were

restung by ants and showed no systemic reactions. He could thus claim 100% effectiveness of therapy. In our series, 19 of 92 patients treated were restung with two systemic reactions, therefore producing, arithmetically at least, a 90% success rate of therapy.

Patient A. B. (Table 4) did have a systemic reaction while well under hyposensitization. However, he has had two subsequent restings with only local reactions at even lower doses of extract, so he may not represent a treatment failure although his course is difficult to explain. Patient J. B. (Table 4) is also extremely interesting. In October 1973 he was restung while receiving 1 to 1000 dilution of imported fire ant extract and had only a local reaction. He was restung again in April 1974 and again in June 1974 while receiving ½ cc of 1:200 dilution and developed only a local reaction. On approximately August 1, 1974 he was stung by six fire ants with no difficulties and was at that time almost at maintenance in his 1 to 10 dilution of extract. On August 16 he was stung by approximately nine fire ants and within an hour began to have severe itching of the hands, flushing of the face, tingling and numbness of the lips and diplopia. He took three prednisone tablets and the symptoms gradually began to subside. Although there were no objective signs, it was not felt that this patient was prone to hysteria. The reason for concern is that, on theoretical grounds, we would expect to find individuals similar to those described by **Lichtenstein**⁸ (in honey bee sensitivity) where certain patients are sensitive only to certain components of the venom and derive no protection from the commercial whole body extract.

There is one additional interesting patient, not counted as a treatment failure, who was mistakenly being treated with Greer red ant extract after a previous systemic reaction to fire ant and positive fire ant skin testing. On reexposure a systemic allergic reaction developed and she was at that time started on fire ant extract. She has not been bitten since.

Skin testing produces a number of false positives⁹ and rare "false negatives" (Table 1). Skin testing then is a good approximation but is not definitive.

There were five patients in the series (including Case 2 who had recently moved to the South) from out of the country or from the northern United States, where they lived all their lives. With no known previous exposure, these five patients had a systemic reaction to their first imported fire ant sting. This is strong evidence that they were initially sensitized through a cross-reacting antigen

probably from other insect exposures. This, together with the cases of individuals with combined hypersensitivity to the imported fire ant and other stinging hymenoptera, suggests clinically at least some cross-reaction.

This is not surprising if one extrapolates from the clinical experience with the other hymenoptera where cross-reaction is common. Several authors have found, using gel diffusion techniques and immunoelectrophoresis, that there were certain shared body proteins between the bees, wasps, bumble bees, and yellow jackets.¹⁰ It was further shown that the highly proteinaceous venom of the hymenoptera contained some of these body proteins in most cases. Although there are exceptions, they do tend to concur with the observed clinical cross-reactivity.

This is not the case with fire ant venom, which contains only minute amounts of protein of a relatively small molecular weight¹¹ while 95% of the venom is composed of a simple alkaloid.¹² Based on this information one would not expect any clinical cross-sensitivity, at least on the basis of a body protein contained in the venom. James *et al* have reported skin testing and RAST data indicating reactivity to synthetic alkaloid and venom in some fire ant sensitive patients.¹³ Claims of effectiveness of hyposensitization are valid only if there have been multiple reexposures over a period of time without systemic reaction. The apparent success rate of hyposensitization therapy remains impressive, however, in this limited number of 27 patients (Dr. Triplett's eight and our 19 patients resting while on hyposensitization therapy).

Effectiveness of hyposensitization with a poorly defined antigen such as fire ant venom is difficult to ascertain. Problems such as spontaneous desensitization of a refractory period immediately after a reaction, and of cross-reactivity from other insect antigens, must be considered. Generally, subsequent exposures will cause increasingly severe reactions, as witnessed in 19 of our 104 patients who had progressively systemic reactions (several being life threatening) prior to presenting to an allergist for treatment. We have no knowledge of the number of patients who have had previous reactions to stings but subsequently did not react and therefore have never come to the attention of a physician.

Nevertheless, the fact that only two of the 19 patients who had been resting after hyposensitization therapy had systemic reactions, appears to point towards efficacy of this treatment. In addition, these two reactions were not severe.

This should induce a trend among primary physicians to refer patients to specialty treatment centers after an initial systemic reaction from a fire ant sting.

One additional point of interest is the problem of cross-reactivity between ant species. Many patients who report systemic reactions from ant bites are skin tested with fire ant antigen and, if found positive, are treated with fire ant extracts alone, without any existing proof that they ever had a constitutional reaction to a fire ant sting. Whether or not fire ant extract injections protect against other ant sensitivity is not known. However, the example of our patient (see discussion) who was treated with red ant extract and subsequently suffered a constitutional reaction to a fire ant sting points out the possibility that cross-reactivity between these two insects is certainly incomplete.

With an apparent increase of the incidence of ant sensitivity in the southern United States, the following questions may be timely: Should there be a skin test battery for ant sensitivity? Should there be a mixed ant extract? What are the antigenic components in ant venom which cause systemic reactions? Present ongoing work may answer some of these questions in the future.

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Clinical Hints to Diagnosis of the Rheumatic Diseases

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A few years ago the thesis was presented that diagnosis of arthritis is made on a clinical basis, that laboratory and x-ray aids are only secondary and sometimes misleading tools.¹ Remembering the comments from colleagues, however, I must confirm that in many instances not only are clinical findings needed but every other available tool, i.e., laboratory, x-ray, bone scan, tomography, synovial analysis and synovial biopsy. Even then an accurate diagnosis may be difficult.

This article merely mentions some clinical hints which may help the astute physician make a proper diagnosis when he first sees the patient.

The differential diagnosis begins when the patient first presents himself. A lurching gait may promptly indicate a far advanced arthritic hip. A stooped male with head flexed forward and limitation of motion in the cervical spine and hips is obviously far along in ankylosing spondylitis. A festinating gait may pinpoint parkinsonism. Alopecia, a butterfly rash on the face, usually correctible ulnar deviations of the hands, periungual erythema, Raynaud's phenomenon and petechiae may pinpoint systemic lupus erythematosus (S.L.E.). A cutout shoe with the bunion joint exposed immediately suggests gout. Swollen knees in an obese female with knock-knees may pinpoint osteoarthritis. Swan-neck and boutonniere deformities usually mean rheumatoid arthritis. The nodule on or just below the elbow, however, may be either a gouty tophus or a rheumatoid nodule. Its location and consistency may take a differential diagnosis, as also may the presence of tophi on the ear lobes or, conversely, rheumatoid nodules on the back of the head, sacrum, ends of fingers or extensor aspects of the knees.

Psoriasis may explain the arthritis subsequently found. A distended and nodular temporal artery may make a diagnosis of polymyalgia rheumatica with temporal arteritis easy while nodular infiltrates along the course of a

peripheral artery may pinpoint classical periarteritis nodosa. Telangiectasis in a patient with pinched facies and inability to open the mouth wide means scleroderma even at this stage although the hands and wrists may be puffy and edematous rather than contracted with infiltration of the subcutaneous tissue and sclerodactyly as seen in the more advanced case. A leathery friction rub on manipulation of the knees and, occasionally, other joints may be further proof.

Pitting of the nails and subungual hyperkeratosis suggests psoriatic arthritis and, less commonly, Reiter's syndrome.^{2,3} Keratoderma blenorrhagica, balanitis circinata, mucoid urethral discharge, usually painless, and shallow mouth ulcers and conjunctivitis make the diagnosis of Reiter's syndrome obvious.^{4,5} Contrary-wise, painful mouth ulcers with conjunctivitis, iritis and uveitis, not to mention peripheral neuropathy and painful ulcers in the vagina and urethra, may suggest Behcet's syndrome.

Sex, age and race frequently offer clues to the correct diagnosis. Rheumatoid arthritis, systemic lupus erythematosus, dermatomyositis, scleroderma, Takayasu's disease, temporal arteritis, Sjogren's syndrome, Felty's syndrome, gonorrheal (GC) arthritis, primary osteoarthritis and the arthropathy of ulcerative colitis have an apparent predilection for the female. Ankylosing spondylitis, Reiter's syndrome, periarteritis nodosa and gout predominate in the male. In the child or younger teenager, rheumatic fever, juvenile rheumatoid arthritis, tuberculosis of the spine and hips, the vasculitic form of dermatomyositis, bacterial and viral arthropathies are primary considerations.

In the middle-aged or elderly patient, osteoarthritis, ochronosis, tuberculosis of the knees, temporal and giant cell arteritis, periarteritis nodosa, polymyositis particularly with neoplasm, Charcot joints, pulmonary hypertrophic osteoarthropathy, scleroderma and pseudogout, become important considerations. In the young adult, Reiter's syndrome, gonorrheal arthritis, ankylosing spondylitis and rheumatoid arthritis are

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major considerations. In the Negro, gonorrheal arthritis, sickle cell disease, sarcoidosis and the more malignant forms of S.L.E. immediately come to mind. The races of the Mediterranean Basin are prime candidates for the amyloidosis of familial Mediterranean fever while Jews have a higher incidence of arthropathy associated with ulcerative colitis.

A more comprehensive examination follows and here the mode of onset, type of spread and present distribution of involvement are extremely helpful. What the patient does not tell may be even more revealing than what he does.

Proceeding next to the physical examination, Table I lists some of the points which have proven helpful to the author. These are arranged largely in sequence depending upon the area of the body, the organ or the organ system involved.

Having completed the general physical examination, the joints and muscles are given particular attention. Several points may be helpful. The palmar surface of the hands and fingers can be used to quickly discover tophi, rheumatoid nodules, areas of subcutaneous infiltration (suggesting eosinophilic fasciitis), tendinous deposits and evidence of pseudohypertrophy. Finally, tenderness on firm but gentle palpation over the trapezi, deltoids and the paraspinal musculature may detect fibrositis.

In examination of the joints, all should be manipulated throughout a normal range of motion to discover limitations. In the metacarpophalangeal (M.C.P.) -metatarsophalangeal (M.T.P.), proximal interphalangeal (P.I.P.), and the distal interphalangeal (D.I.P.), fixation of the joint with the thumb and index finger of one hand while manipulation is attempted with the corresponding fingers of the other hand should help to differentiate soft tissue swelling of fusiform character due to rheumatoid arthritis from bony overgrowth and irregularity such as one may see with Heberden's or Bouchard's nodes or with tophi. Tests for both thoracic inlet and outlet syndromes are important as also is a search for bruits over either the carotid or subclavian arteries which may explain some of the patient's presumed primary muscle or joint problems.

In the lower back, limitation of motion may indicate an early ankylosing spondylitis. This may be quite minor and difficult to detect. It may be necessary to fix the patient's pelvis so that he cannot move his hips and give a false impression of greater range of motion in the lumbar spine than is actually present.

Pain and tenderness of the hands, wrists, elbows and knees frequently out of proportion to the objective findings and often localized more to one side of the joint than the other may be the clue to hepatitis B infection and urticarial; petechial or macular rashes and tender erythematous subcutaneous nodules will strengthen this suspicion.⁶

A careful examination of the feet is necessary. Rheumatoid arthritis manifests itself as often in the lower extremity as it does in the upper. Finally, a careful search for effusions in various joints may be helpful particularly in the knees where fixing the patella and tapping only on one side of the joint may elicit fluid on the other side, otherwise not detected.

The sum of all signs and symptoms make the diagnosis. For example, symmetrical joint involvement with soft tissue swelling and/or effusion involving particularly the smaller rather than the larger peripheral joints in a female usually means rheumatoid arthritis. Symptoms in similar joints but very little objective evidence of arthropathy and with correctable deformities will frequently mean systemic lupus erythematosus. Bony overgrowth particularly in the proximal and distal interphalangeal joints with or without involvement of larger joints will separate osteoarthritis from rheumatoid arthritis. Asymmetrical joint involvement, particularly when it starts in either the big toe, ankle or knee on one side, and over a period of time progresses, strongly suggests gout. In its onset and evolution pseudogout, however, may resemble gouty arthritis, rheumatoid arthritis, osteoarthritis or a septic joint. Monoarticular arthritis will suggest acute infectious arthritis or neoplasm. An obviously disorganized and Charcot-type joint will suggest syringomyelia if the upper extremity is involved, syphilis if a larger joint in the lower extremity is involved, and diabetes mellitus if the disease involves the smaller joints of both hands and feet.

Sarcoidosis may produce an unusual dactylitis. Recurrent episodes of "sciatic neuritis" may suggest early ankylosing spondylitis. Distribution of muscle weakness in the shoulder and pelvic girdle either without pain or only mild pain might point to polymyositis - frequently due to an occult neoplasm. Pain in a similar area with no muscle weakness may mean polymyalgia rheumatica with or without underlying temporal arteritis and giant cell arteritis. Segmental arterial or venous infiltrates in the presence of multisystem disease coupled with arthralgias, arthritis or muscle weakness may indicate periarteritis nodosa.

TABLE I

A.

HEAD AND NECK

The finding of:

1. Dry eyes, filiform conjunctivitis or superficial ulcerations of the cornea
2. Posterior capsular cataracts
3. Acute iritis
4. Bluish areas in the sclerae
5. Cytoid bodies on ophthalmological examination
6. Chronic uveitis

Should suggest:

1. Sjogren's Syndrome
2. Juvenile rheumatoid arthritis
3. Juvenile ankylosing spondylitis
4. Early scleromalacia perforans in severe rheumatoid arthritis
5. S. L. E.
6. Sarcoidosis.

B.

HEART AND LUNGS

The finding of:

1. Signs of restrictive ventilatory disease
2. An infiltrative process in the lung
3. Pleural effusion
4. Pericarditis
5. Myocardial involvement
6. Aortic insufficiency
7. Mitral insufficiency
8. Libman-Sacks endocarditis
9. Reverse coarctation of the aorta in a young female
10. Shoulder-hand syndrome

Should suggest:

1. Early scleroderma with pulmonary involvement
2. a. Caplan's Syndrome
b. Recurrent atelectasis and/or transitory pneumonia of S. L. E.
c. Wegener's granulomatosis
d. Transitory pulmonary infiltrates of granulomatous angiitis
3. a. S. L. E.
b. Rheumatoid arthritis
4. a. Rheumatoid arthritis
b. S. L. E.
c. Other collagen vascular disease
5. a. Rheumatoid arthritis
b. S. L. E.
c. Periarthritis nodosa
d. Amyloidosis of long standing rheumatoid arthritis
6. Ankylosing spondylitis
7. Rheumatoid arthritis
8. S. L. E.
9. Takayasu's Disease
10. a. A recent myocardial infarction
b. A recent hemiplegia

C.

ABDOMEN

The finding of:

1. Swallowing difficulties
2. Symptoms suggestive of reflux esophagitis
3. Recurrent diarrhea
4. Symptoms suggestive of a malabsorption syndrome
5. Symptoms suggestive of visceral crises
6. Palpable and apparently enlarged kidneys

Should suggest:

1. Polymyositis. Confirm by x-rays showing problems related to the upper end of the esophagus and diffuse calcific deposits in the peripheral musculature.
2. Scleroderma. Confirm by G.I. x-rays demonstrating a dilated and non-functioning esophagus; a dilated and infiltrated duodenal loop; A sprue-like picture in the small bowel with malabsorption syndrome and/or large, wide-mouth diverticula of the colon.
3. Regional enteritis or ulcerative colitis with associated spondylitis and peripheral arthropathy
4. Whipple's Syndrome - confirm by dark pigmentation of the skin, anemia, weakness and positive jejunal biopsy.
5. Lead gout: Familial Mediterranean fever, Sickle cell disease, leukemia or periarteritis nodosa.
6. Amyloidosis

Discussion

The point here is that in many instances a diagnosis of arthritis may be made largely on a clinical basis and frequently when the patient first presents himself provided a careful history and physical examination is performed. No attempt has been made to set forth a complete compilation of findings which is the purview of the formal text on rheumatology. Instead, these clinical clues are offered to you as they have been helpful to me.

Reprints are available from the Author.

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VICTORY THROUGH YE OLDE AIRPOWER

We were attending the outdoor historical drama, "Horn in the West," in Boone, N. C. The battle of King's Mountain was being portrayed most realistically, almost too much so for a ten-year-old boy who was living and dying with each battle casualty.

The arena was filled with smoke from the exploding "shells", and sand from the dirt floor of the amphitheater was showering patrons as far back as the sixth row. This totally engrossed youngster was jumping up and down while alternately covering his eyes and ears with cupped hands.

Just as all appeared lost for the Colonial soldiers, the roar of jet engines was heard above the din of this unfolding Revolutionary battle. Uncovering his eyes, this lad of modern-day televised battles jumped to his feet and with jubilant rebel yell exclaimed, "Granddaddy, granddaddy! Here come the bombers!"

Moments later the sound of exploding shells had ceased and the smoke-filled arena cleared, revealing that all of the Red Coats were either dead or routed and, to one at least, the invincibility of airpower had once again been affirmed.

Contributed by Col. James Basil Hall, M.D. (Ret.) Reprinted from The Medical Journal of Australia, January 15, 1977.

Physicians Needed for Indian National Health Services

Project USA—the American Medical Association's program to recruit physicians for short-term service—has year round vacancies at Indian Health Service facilities and National Health Service Corps rural communities.

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Hereditary Fructose Intolerance in a Male Infant

A. Garnica, M.D.

Abstract: A male infant is presented who, at age two weeks, had progressive symptoms of vomiting, diarrhea, and failure to thrive, with jaundice, hepatomegaly, hypoglycemia, and acidosis, which did not improve with lactose restriction. The resolution of all clinical abnormalities with fructose restriction, however, led to the presumptive diagnosis of hereditary fructose intolerance, a potentially fatal but treatable inborn error of carbohydrate metabolism. The diagnosis was confirmed by demonstration of decreased aldolase B activity in liver and intestine.

The demonstration of a reducing substance in the urine of a newborn infant with jaundice, hepatomegaly, vomiting, hypoglycemia, metabolic acidosis, and failure to thrive classically signals the diagnosis of galactosemia.¹ These clinical findings in an infant whose symptoms do not improve with lactose exclusion, however, may also be seen in tyrosinosis, fructose-1, 6-diphosphatase deficiency, and hereditary fructose intolerance (HFI).^{2, 3} Among these four disorders the most responsive to therapy is HFI. Although the incidence of this condition is not known and the actual number of reported cases may be relatively low, its recognition and treatment are important because of the tragic consequences of nontreatment in contrast to the responsiveness of all metabolic abnormalities and symptoms to simple sucrose, fructose, and sorbitol restriction.^{2, 4} The following report illustrates the typical onset and progression of hereditary fructose intolerance in a young infant, its clinical and enzymologic diagnosis, and its response to dietary restriction.

Case Report

W. C. was the 2400 gm product of an uncomplicated term pregnancy, labor and delivery, born to a 24-year-old secundigravida with an unremarkable family history. He thrived on Similac^{*} formula until the age of two weeks when rice cereal

feedings were introduced. During the next week, however, he began having recurrent episodes of forceful vomiting and his formula was changed to Isomil.^{*} Fruits were introduced at the same time but quickly discontinued when they consistently produced vomiting. After transient improvement, however, the vomiting increased in frequency, diarrhea developed, and he was hospitalized at the age of five weeks. Three days later he was transferred to the Shands Teaching Hospital, University of Florida. On admission he was noted to be a thin, irritable, chronically ill-appearing, icteric infant who regurgitated several times during his examination. His height was 54 cm, weight 3520 gm, and head circumference 35 cm. Significant findings included a liver palpable 6 cm below the right costal margin with a liver span of 12-13 cm. The spleen was not palpable. Laboratory studies included hgb 11.0 gm/dl, hct 32%, WBC 16,600 with a normal differential, and platelet count 260,000; prothrombin time was 13.2 sec. (control 9.7), partial thromboplastin time 90 sec. (control 34), and thrombin time 22.3 sec. (control 15.9); serum sodium 135 mEq/l, potassium 4.9 mEq/l, bicarbonate 18 mEq/l, chloride 103 mEq/l; BUN 3 mg/dl, creatinine 0.6 mg/dl, fasting blood glucose 102 mg/dl; SGOT 240 iu/L, SGPT 94 iu/L, leucine aminopeptidase 24 iu/L (8-22), gamma glutamyl transpeptidase 89 iu/L (0-45), alkaline phosphatase 460 iu/L, total bilirubin 6.2 mg/dl with direct 4.0 mg/dl; serum total protein was 5.1 gm/dl; hepatitis B antigen was negative, alpha₁ antitrypsin 250 mg/100 ml (212 + 32), rubella titer 1:20; VDRL, toxoplasmosis, and cytomegalovirus titers were negative; the urine specific gravity was 1.0006, pH 6, glucose and protein negative, acetone trace. Metabolic screen demonstrated 1+ reducing substance, negative glucose, 1+ protein, 2+ ketones, and basic aminoaciduria. AP and lateral roentgenograms of the chest, barium swallow, upper G. I. series, and barium enema were normal, but there was marked demineralization of the bones. On the day of admission he was started on feedings of Polycose,^{*} a formula containing neither sucrose nor protein. Within seven days the serum bilirubin had decreased to 2.0 mg/dl, with SGOT 84 iu/L and SGPT 46. Because of this response to Polycose and a retrospective history associating the onset of symptoms with the introduction of sugar-dipped pacifiers, a presumptive diagnosis of HFI was made and his feedings changed to Pregestimil^{**} formula. The diarrhea gradually resolved, the liver functions continued to improve on the Pregestimil-Polycose combination, and the infant was discharged after a 12-day hospitalization with a total bilirubin of 1.1 mg/dl, SGOT 69, and SGPT 24.

The infant did well on a restricted diet and was subsequently readmitted at the age of seven months for final diagnosis. He was noted to smile, laugh, and play, but his head control was poor and he could not roll over or sit without support. His height was 70.5

^{*}Similac, Isomil: Ross Laboratories

^{*}Polycose: Ross Laboratories

^{**}Pregestimil: Mead-Johnson Laboratories

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cm (85%), weight 6.54 kg (<3%), and head circumference 42.3 cm (<3%). The liver was palpable 5 cm below the right costal margin, liver span 8-9 cm, but there was neither jaundice nor splenomegaly. Laboratory studies included a normal urinalysis, hemogram, platelet count, prothrombin time, partial thromboplastin time, serum electrolytes, fasting blood glucose, BUN, creatinine, calcium, and phosphate. EEG, ophthalmologic evaluation, urea clearance, creatinine clearance, and tubular reabsorption of phosphate were normal. SGOT was 46 iu/L (7-40) and SGPT 46 iu/L (6-53). Serum glucose, phosphate, and SGOT were measured after an intravenous dose of 1.0 gm of fructose (3.0 gm/m²): blood glucose at 0, 30, 60, 90, and 120 minutes were 90, 52, 84, 79, and 86 mg/dl respectively; serum phosphate was 6.4, 4.4, 5.8, 6.1, 6.3 mg/dl; SGOT at 0, 60, and 120 minutes as 46, 55, and 54 iu/L respectively (Fig. 1). The day after the fructose tolerance test, an open biopsy of the liver was obtained and demonstrated the following microscopic appearance: Most hepatocytes had a pale, vacuolated, granular cytoplasm with a centrally located nucleus, but others in the periportal areas were distended with large fat droplets, displacing the nucleus peripherally. These fatty changes were thought to be consistent with early changes of fructose intolerance.

The activities fructose-1-phosphate aldolase and fructose-1, 6-diphosphate aldolase were measured in biopsy specimens from the liver and small intestine as the rate of decrement in absorbance at 340 nm, which results from the oxidation of NADH.⁸ Both enzyme activities were reduced in both tissues and were consistent with reported values (Table 1).⁸⁻⁹

On a diet free of sorbitol, fructose, and sucrose, the Infant has remained asymptomatic. His condition has improved progressively, although his developmental milestones continue to be delayed.

Discussion

The incidence of HFI, or fructosemia, in the United States has not been determined possibly because of the relatively small number of recorded cases. Its frequency, however, is probably greater than generally recognized because of the facility with which the abnormal symptoms may be completely controlled by a patient through the simple exclusion from his or her diet of foods which cause nausea, vomiting, diarrhea, and systemic discomfort. However, both onset and severity of symptoms are determined by the age at which fructose-containing foods are introduced. The most severe manifestations occur when sucrose (table

sugar), a glucose- and fructose-containing disaccharide, is introduced before the infant is able to reject feedings. The continued feeding of fructose-containing foods to young infants with HFI ultimately results in severe hepatorenal dysfunction including hypoglycemia seizures, metabolic acidosis, hepatosplenomegaly, bleeding tendencies, and profound hypoproteinemia with anasarca.⁸

The primary defect in HFI is a decrease in the affinity of hepatic, renal, and intestinal aldolase B for its substrates, fructose-1-phosphate and fructose-1, 6-diphosphate, which results in a deficiency of fructose-1-phosphate aldolase and fructose-1, 6-diphosphatase activity.^{8, 9} The pathogenesis of the biochemical changes seen in HFI is not completely worked out. However, the administration of fructose to a patient with this disorder results in the accumulation intracellularly of high concentrations of fructose-1-phosphate, which inhibits glycogenolysis and gluconeogenesis, producing a glucagon-unresponsive hypoglycemia.¹⁰ The sequestration of fructose-1-phosphate is associated with a degradation of cyclic nucleotides, loss of intracellular magnesium, transport of inorganic phosphate intracellularly, and decrease in protein synthesis.^{2, 11}

Clinically, fructose ingestion causes nausea, vomiting, and diarrhea. The infusion of fructose, as in a fructose tolerance test (Fig. 1), causes transient hypoglycemia, hypophosphatemia, hypermagnesemia, and increased serum transaminases. Associated serum abnormalities are prolonged fructosemia, increased serum free fatty acids and glycerol, methioninemia, tyrosinemia, lactic and pyruvic acidemia, ketoacidemia, and hyperuricemia.^{3, 8} The renal response consists of a complex disturbance of proximal tubular function with impaired reabsorption of amino acids, glucose, phosphate, uric acid, and bicarbonate.¹² Mental retardation has not been reported as a consequence or in association with hereditary fructose intolerance, and there have been no irreversible, long-term renal, hepatic, or neurologic sequelae reported in adults or children with hereditary fructose intolerance.^{3, 8}

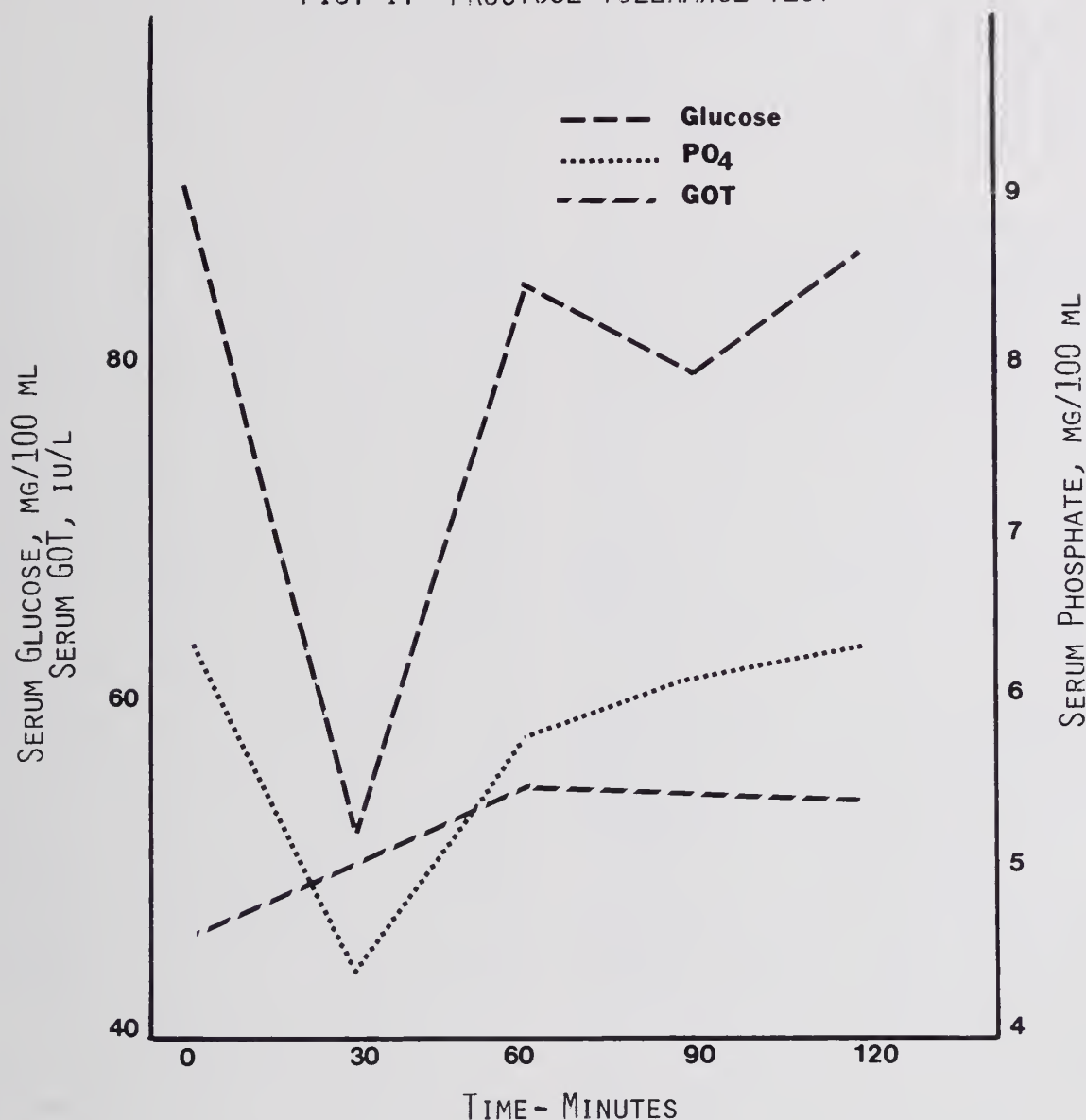
The present case illustrates the similarities between galactosemia and hereditary fructose intolerance, two autosomal recessive inborn errors of carbohydrate metabolism. Early onset, symptomatic HFI must be considered in any infant who presents with hypoglycemia, jaundice, and hepatomegaly. All symptoms and complications may be controlled with appropriate dietary restriction while failure to treat leads to severe neurologic dysfunction and early death.⁴

TABLE 1

Aldolase Activity (μM Substrate Utilized per Minute per Gram)

	F-1-P	F-1,6-DiP	F-1,6-Dip/F-1-P
Patient: Liver	0.19	1.42	7.5
Jejunum	0.13	0.37	2.8
Normal: Liver	6.0-14.0	6.0-14.0	1.0-1.1
(6,7) Jejunum	1.1	1.9	1.8

FIG. I. FRUCTOSE TOLERANCE TEST



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Ambulatory Surgical Care

Thad Moseley, M.D.

After World War II there was a rapid increase in the number of well-trained surgeons, a tremendous expansion of the surgical specialties, a many-times increase in hospital beds, a quantum leap in sophisticated diagnostic equipment, and a rapid increase in our understanding of "why disease." The surgeon's office, formerly the site of much minor surgery, was replaced by the emergency room with its available conveniences and in many instances became a carpeted consultation room. Anesthesiology came of age and surgeons welcomed the assistance of a well-trained anesthesiologist for patients requiring major surgery and eventually for any patient requiring surgery.

The patient benefited from such care and with the increase in third party payments began to expect and demand hospital care for any needed treatment. In turn the third party payer reinforced this demand for hospitalization by emphasizing payments for hospital care and de-emphasizing payments for outpatient care.

Hospitals continued the traditional spread of all costs over the entire patient population using this broad patient base and all supporting services to cover the monetary needs of the institution, rarely charging the patient for the actual cost of service or procedure whether it be large or small.

There became apparent a need to offer surgical care with trained anesthesiology assistance in a controlled environment with cost to the patient based upon the actual expense involved — a system recognized by insurance carriers and one with arrangements for more sophisticated patient care if such was needed. To meet this need came the ambulatory surgical care concept.

Primary Settings

Ambulatory surgery, or in-and-out surgery, is performed in four primary settings:

First is the office or clinic setting. The advantages are low cost to the patient, efficient use

of physician time, rapid service to the patient, and a limited loss of his productive time. Disadvantages include absence of quality control, facilities for care of emergency situations, ancillary personnel to assist if reaction should occur, and also the policy — now changing — of third party payers covering only in-hospital services.

Second is the hospital emergency room. This is no place for elective surgery yet surgeons use this facility for personal and patient convenience. Consequently we are educating a patient generation to look to the institution for care and are weakening a personal relationship that should be preserved.

Third is the hospital-based facility. There are many variations ranging from a separate administrative and clinical facility sharing the many ancillary services with the formal hospital to an admission in the morning, utilization of routine administrative and professional services and discharge in the evening. The hospital has the advantage of patient acceptance, equipment and personnel to make such a service possible with minimal cost and maximal safety but many institutions are so enraptured with organizational habit that the cost advantage, patient convenience, and the minimal time advantages are lost.

Fourth is the free-standing ambulatory surgery facility. With planning, quality can be assured, cost can be reasonable for service rendered, trained personnel can be employed for specific services, and the patient can receive care with minimal interruption of normal routine and positive psychologic impact. Complications, however, may still require ancillary services; also a community with an excess of hospital beds may find overall health cost increasing as the new facility produces more empty beds in existing hospitals and leaves only the more complicated patient care for these hospitals.

Procedures

What procedures should be done in an ambulatory facility? In the office a procedure should not be painful using an anesthesia providing

Presented before the 1976 Clinical Congress of the American College of Surgeons in Chicago, October 12, 1976.

an adequate degree of relaxation for a patient whose physical condition appears good for a procedure that is a limited or superficial one.

In an ambulatory unit, important considerations are the absence of secondary disease, presence of a responsible person at home, and physician's relationship to and understanding of the patient. It is easier to delineate the areas that are not suitable for in-and-out surgery: cavitary exploration; complicating cardiac, renal or respiratory disease; unexplained fevers or anemias; need for prolonged professional care in the recovery period; no responsible care in the home environment; physician-patient relationship that is not ideal. Common sense should alert the surgeon to the patient and the disease which is not amenable to ambulatory care.

For an ambulatory surgery unit to fill the community need it must be licensed as any health facility. It must be inspected at regular intervals by an accredited inspection unit such as the Joint Committee for Accreditation of Hospitals (JCAH). It must assure quality care by formal planning and supervised evaluation. It must be a part of the health system and not further fragmentation. It must reduce overall community health care cost. It should maintain a physician-patient relationship. The cost in time and money to the patient must be less than that for a similar service in a formal hospital setting. Third party payers must accept the responsibility of reimbursement at the same level as is customary for the community. The community must accept such a service as one that is needed and desirable.

Effect Upon Surgeons

An estimated \$135 billion will be spent for health care this year, approximately 25% for surgical care. Statistics demonstrate that the cost of ambulatory surgical care is 20% to 50% less than a similar service rendered in a formal hospital setting. Third party payers and the federal government are aware of these figures as they search for methods that will control cost while assuring quality care. At the legislative level, the federal government is making every effort to pass legislation that will assure medical care for all and impose controls in the dispensing of professional and general medical services. We surgeons must take the initiative in this effort if we are to have quality care.

The Department of Health, Education, and Welfare (HEW) is now studying six Free-Standing

Ambulatory Surgical Units. The Orkand Corp., Silver Springs, Md., is collecting these data and this report should have been available January 1, 1977. Assuming it substantiates the lower individual cost, and in proper situations lower community cost, of a unit service performed in an ambulatory health care facility, HEW can be expected to encourage such a facility.

Hill-Burton statistics obtained from HEW state that of the hospital beds in this country, assuming a 77% occupancy rate, about 40,000 unneeded beds exist. Bed occupancy, special service bed needs, and sophisticated equipment location and use have been documented in areas which had a Community Health Planning Council. Many of these planning councils have been designated as a Health Systems Agency (HSA).

The HSA exists to "improve the health of residents of a health service area," increasing the accessibility, "including overcoming geographic and transportation barriers," acceptability, continuity, and quality of the health services provided them, restraining increases in the cost of providing health services, and preventing unnecessary duplication of health resources." In Florida there are three laws which mandate HSA review of New Institutional Health Services:

1. Health Facilities Planning Act of 1975 or State Certificate of Need, a state law.
2. Federal Capital Expenditure Review.
3. PL 93-641, which requires predevelopment review of NIHS projects under the State Certificate of Need process.

These laws require the HSA to review and to make recommendations on any project that involves the addition of beds or new construction of beds or any expenditure of \$50,000 or more for a nursing home or ambulatory surgical center. HSA also must review the conversion of one type health care facility to another.

Since conversion of existing beds or construction of new beds must be justified by HSA review with referral to the state for final approval and granting of a certificate of need before such a service can become a reality, and knowing that there are unused hospital beds in many communities, if HEW finds that development of ambulatory surgical units will lower the cost of surgical care, then it seems wise that the surgeon use his influence to develop a facility which: utilizes unused hospital beds, satisfies the requirements of PL 93-641, conforms with the May 1976 Accreditation Manual for Ambulatory Health Care

published by JCAH, meets the levels of care as prescribed by the local Professional Standards Review Organization, and qualifies for third party payment for services rendered by the facility and by the physician. It appears that in-hospital development of such a service will more frequently meet these requirements.

Conclusion

There is a need for ambulatory surgery facilities. Development depends upon community

needs, physician desire and public acceptance. It is clear that the office, emergency room, hospital based unit and independent facility wisely used can provide quality care at minimal cost. Ideally each surgeon should utilize existing facilities, working to provide a setting capable of meeting the patient's needs with minimal trauma to the patient and to the family, at a cost commensurate with the service rendered.

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Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

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Emergency Treatment for Serious Insect Stings

S. D. Klotz, M.D.

There is a surprising paucity of understanding among many physicians, paramedical and lay persons on the potential seriousness of insect sting and bite reactions, which can produce anaphylactic reactions so severe that rapid death may ensue. It is suspected that insects cause many more deaths than are actually recorded or recognized. Physicians are known to certify heart failure, coronary thrombosis, or stroke as the cause of death even when there is positive evidence or testimony of an insect sting minutes before the sudden death.

Of the three most important groups of venomous animals in the United States, hymenoptera, snakes, and spiders, it is the hymenoptera that kills the most people, even more than the feared rattlesnake.

In the hymenoptera order, the wasps, hornets, yellow jackets, and in particular the bees, have been the most frequent offenders, but now the fire ant has been added to this list of the most common insects whose stings may lead to severe and even fatal hypersensitivity reactions. Deaths have occurred with alarming suddenness, within 15 to 30 minutes, so that the victims were seen by a physician only after death. The interval from sting to severe symptoms may range from immediate to 30 minutes, but most often within 2 to 10 minutes.

Thus it is obvious that people who are sensitive may require emergency care to keep them alive until they can be transported to a medical facility. These people should be able to self medicate if stung; in case of a child the parents should be given the proper instructions. Emergency insect sting (anaphylactic) kits can be made up or purchased

which contain epinephrine hydrochloride (1:1000) in preloaded hypodermic syringes. The kit should also contain antihistamine tablets, tourniquet, and a sterile alcohol pad. Our office instructs the patients or guardians on how to use the emergency kit including how to give a hypodermic injection. This is no radical innovation as diabetics for many years have been taught how to self administer insulin.

Emergency kits* should also be available to personnel who are frequently called upon to render first aid. I am referring to forest rangers, rescue squad personnel, trip leaders such as scoutmasters, and school nurses. Victims within their range but far from a medical setup may require immediate relief from anaphylaxis. Training lay personnel is not unusual. Look at the recent spread of cardiopulmonary resuscitation teaching programs that have saved many lives where this has been instituted. If community laws do not permit lay personnel to give emergency injections, these should be repealed.

If an individual who has suffered an anaphylactic reaction from an insect sting is found without respiration and/or pulseless, mouth-to-mouth respiration and cardiac massage should be instituted in addition to giving epinephrine injections.

*Emergency kits are commercially available and can be purchased in any pharmacy. Center Laboratories, Inc., Port Washington, N.Y. 11050, has a packaged kit called Insect Sting First Aid Kit. Hollister-Stier Laboratories, P. O. Box 19957, Atlanta, Georgia 30325, has a packaged kit it called "Ana-Kit" for Emergency Insect Sting treatment of patients. Its preloaded syringe allows for the administration of two measured doses of 0.3 cc each, if required.

Who are the patients prone to have anaphylactic responses to insect stings? The ones who have had more than a local reaction in the area of a sting and in whom general symptoms have developed such as urticaria, itching, dizziness with tightness of the chest, and wheezing. These people have a very good chance to develop a more severe generalized reaction, progressing sometimes to shock and death with subsequent stings.

The preloaded 1 cc syringes that are commercially available are calibrated so that they can accurately deliver from 0.25 to 0.50 cc to an adult and from 0.20 to 0.40 cc to children. Since the action of epinephrine is short lived, if symptoms begin to return within 20 minutes, the injections should be repeated. An epinephrine aerosol (Medihaler Epi) can be used if there is upper airway edema or asthma. The antihistamines which act slowly are taken after the injection. If the extremities have been stung, a tourniquet can be placed above the sting following the usual precautions in its use.

Those who are sensitive should be instructed to avoid being close to outside cooking, strong odors, garbage areas, gardening and lawn mowing, the wearing of bright colors, and perfumes. Such individuals should receive specific hyposensitization therapy. Present data indicate that this treatment is effective in reducing or eliminating subsequent reaction to stinging insects. Whole body insect extracts are used at this time. Pure venom is believed to be a more specific and suitable therapeutic antigen in bees, but is not yet available.

- Dr. Klotz, 303 East Par Avenue, Orlando 32804.

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SPECIAL ARTICLE

The Florida Medical Association's Continuing Medical Education Program — What Every Member Should Know

Introduction

Continuing education has always been a necessity, a part of life to most professional disciplines. This is particularly true in medicine, an area of scientific knowledge which has burgeoned at a remarkable rate. Indeed, the physician who makes no reasonable effort to "keep up" will soon be out-of-date, inviting a "substandard" designation by his contemporaries.

Continuing medical education, or CME as it is often called, did not begin its rise to present prominence in most physicians' lives until perhaps the 1960s. As medical knowledge expanded, there was a demand that the profession keep pace. Some medical societies perceived a pertinent role for themselves. For many years, the American Academy of Family Physicians set educational standards for its members. Following the lead of the Academy, several national specialty societies now encourage CME participation, and several certifying boards require or plan to require re-examination and recertification of their diplomates at appropriate intervals. Oregon became the first state medical association to adopt a mandatory postgraduate education requirement.

Meanwhile, "legislated CME" became a popular topic and a threat. Bills embodying that concept were introduced in several state legislatures. A few legislatures required physicians to submit evidence of participation in CME as a prerequisite to relicensure.

The Florida Medical Association's mandatory CME program for members was born May 6, 1972, when the House of Delegates, acting upon the recommendation of the Council on Scientific Activities, decreed

"That 30 hours of continuing medical

education be established as a minimum requirement for maintenance of Association membership to become effective January 1, 1974, with guidelines and procedures for fulfilling this requirement to be developed by the Committee on Continuing Medical Education for presentation to the House of Delegates in 1973."

One year later the House approved the basic format of the program as proposed by the Council on Scientific Activities. As enacted at that time, physicians were required to complete 90 hours of CME within a three year period to maintain their regular active Association membership. Of these 90 hours, at least 60 were required to be in the "Mandatory" category, and as many as 30 could be in the "Elective" classification.

A word about the reason for creating the FMA "Mandatory" Category is in order. At the time the FMA program was established, there were few AMA accredited institutions in Florida, thus severely limiting the number of Category 1 Credit offerings available to Florida physicians. To enable FMA members to have greater access to quality CME, and at minimal cost, the "Mandatory Credit" category was established. A mechanism to review programs for Mandatory Credit was established within the Committee on Continuing Medical Education. It was established so that local involvement be primary in all aspects of the mandatory program.

Each three-year reporting period is called a "cycle." All members were to be on the same cycle with the first one beginning on January 1, 1974, and ending on December 31, 1976. Then all members would begin their second cycles on the same date, i.e., January 1, 1977. No provision was made for

staggered cycles.

The original program also spelled out procedures for members to use in filing reports, appeal mechanisms, etc.

Practical application of the program has necessitated a number of modifications by the Board of Governors and House of Delegates, as well as interpretations by the Committee on Continuing Medical Education. The requirements and provisions of the CME program as they exist today are described in the appropriate sections of this booklet.

I. - Who Must Participate

Generally, all regular active Florida Medical Association members are required to participate in the mandatory continuing medical education program. It likewise applies to associate members who are practicing medicine, including those physicians who are in provisional membership status with their county medical societies.

Honorary members of FMA, life members, and members who have completely and permanently retired from active practice, either through choice or through disability, are exempt and need not participate unless they wish to do so.

It should be stressed that only *complete and permanent* retirement totally exempts one from the requirements. A physician (not a life member) who is semi-retired and still treating some patients or making decisions regarding medical care will be expected to participate in CME to some limited extent. Such physicians may request a reduction in required hours (See Section XII, Exemptions and Extensions).

II. - Cycles

Each physician subject to the CME requirements must accumulate a certain amount of credit within a three-year cycle consisting of three consecutive calendar years. For a new member, the first cycle begins on January 1 immediately following the date he first became a member of his county medical society, provisional or otherwise.

Older members were permitted to begin their first three-year cycle on January 1, 1974; January 1, 1975; or January 1, 1976. These cycles end, respectively, on December 31 of 1976, 1977, and 1978, with the second cycle beginning the very next day (January 1). A member may earn all of his required credit in any one year of the cycle, if he chooses. However, he may not carry over surplus credit earned in one cycle to the next cycle.*

III. - Methods of Fulfilling Requirements

There are three major ways in which the CME requirements may be fulfilled:

1. *Physician's Recognition Award.* - The American Medical Association's Physician's Recognition Award (PRA) is granted to any physician who demonstrates he has met certain continuing education requirements, irrespective of whether he is an AMA member. Requirements include a minimum of 150 hours of postgraduate study during a three-year period, including at least 60 hours of Category 1 material (See Section IV, Mandatory Credit). The PRA is a certificate that a physician may present to his county medical society as prima facie evidence he has complied with the FMA requirements.

The PRA will cover a physician, as far as the Florida requirements are concerned, for a three-year cycle beginning on January 1 of the year following the date on which the PRA was awarded. It is the responsibility of the individual physician to provide his county medical society with a copy of his PRA.

Physicians who have qualified for the CME certification programs sponsored by the following medical organizations are also considered as qualified for the PRA:

American Academy of Family Physicians (see below)
American College of Obstetricians and Gynecologists
Arizona Medical Association, Inc.
California Medical Association
Oregon Medical Association
American Society of Clinical Pathologists—College of American Pathologists
Pennsylvania Medical Societies

Physicians holding valid educational certificates from any of those organizations may complete their Florida requirements by sending copies to their county medical societies directly. They need not receive the PRA first.

2. *Certification by the American Academy of Family Physicians.* - Any active member of the Florida Academy of Family Physicians whose study reports lead to his re-election to the American

*The American Academy of Family Physicians allows its members to carry over as many as 20 Prescribed hours from one three-year period to the next, provided they are in excess of the 150 required in total and in excess of the 75 Prescribed required for the period. Carryover is on a one-for-two basis, i.e., 16 excess Prescribed hours are reduced to 8 if carried over. FMA members who use recertification by the Academy to meet the FMA CME requirement may take advantage of this carryover provision.

Academy of Family Physicians for a new three-year period will be deemed to have met the FMA's CME requirements for the same period or cycle. If, for example, a family physician garners 150 hours of acceptable credit during the period January 1, 1974, through December 31, 1976, the Academy re-elects him to membership for the period January 1, 1977, to December 31, 1979. From the CME point of view, his FMA membership also is maintained for 1977-79. An active member of the Academy need not report his re-election or recertification to his county medical society. The Florida Academy of Family Physicians will do this report for him. Members of the Florida Academy of Family Physicians who are not in the active membership category with the Academy must personally file CME reports with their county medical societies if they are not exempt from the FMA requirements.

3. *Completing and Itemizing 150 Hours of Education.* - Physicians who are not members of the Academy of Family Physicians and who do not make application for the Physician's Recognition Award must file an itemized Continuing Medical Education Reporting Form (Form 76PF-142) with their county medical societies, directly or through their FMA-recognized specialty groups (See Section VIII, Methods of Reporting).

The report may be filed as soon as all hours are completed, but should be in the hands of the county medical society no later than January 31 of the year following the three-year cycle for which the report is made.

The member must list on Form 76PF-142 each educational activity for which he claims credit, the location, sponsor and date, as well as the number of hours claimed. He must list at least 150 hours, including a *minimum* of 60 Mandatory hours and a *maximum* of 90 Elective hours.* A physician may report as many Mandatory hours as he wishes.

4. *Another Approach.* - In addition to those avenues explained above, the Committee on Continuing Medical Education has been interested in specialty board certification and recertification as an alternate mechanism. The Committee will consider certification in lieu of hour-by-hour reporting on an individual specialty basis and then only upon the recommendation of the FMA-recognized specialty group representing that specialty in Florida. The requesting organization

must present documentation that preparation for a successful writing of the boards is tantamount to earning 150 hours of credit as required in the other avenues. It must also provide pass-fail statistics for recent examination sessions.

Under these conditions, certification would be accepted as fulfillment of the FMA CME requirement for the one three-year cycle in which certification is awarded. For example, a physician who is on a 1977-79 cycle and is certified at any time during that period will be considered as having completed his CME requirement for that period only.

Physicians interested in this approach to completing their CME requirements should contact their FMA-recognized state specialty group or the FMA Committee on Continuing Medical Education for an up-to-date listing of accepted specialty boards.

IV. - Mandatory Credit

The three major organization-sponsored CME programs discussed in this pamphlet (AAFP, AMA and FMA) all require a minimum amount of premium-type credit. AAFP has Prescribed Credit, and the AMA uses the term "Category 1." In the FMA, we are concerned with "Mandatory" Credit.

People often are confused by these terms and mistakenly use them interchangeably. In all three cases, these terms are applied by their sponsors to reflect substantive educational material from which physicians stand to benefit and learn most. Beyond that, they are not synonymous.

FMA established Mandatory Credit and provided a review system to assure Florida physicians of an ample number of quality educational opportunities at reasonable or no cost.

The Academy of Family Physicians approves for Prescribed Credit programming that has an applicability to family practice and which is sponsored or co-sponsored by a medical school (in cooperation with its Department of Family Medicine) or by some level (national, state or local) of the Academy. The FMA gives Mandatory Credit to any AAFP program approved for Prescribed Credit.

AMA's Category 1 required compliance with the concept of "a planned program of CME." This is defined as "one having sufficient scope and depth of coverage of a subject area or theme to form an educational unit that is planned, coordinated, and administered and evaluated in terms of educational objectives that give a defined level of knowledge or a specific performance skill to be attained by the

*For three-year cycles beginning on January 1, 1974, or January 1, 1975, 90 hours were required. All subsequent three-year cycles carry the 150-hour requirement.

physician participating in the program." In addition, a Category 1 offering must be sponsored or co-sponsored by an institution or organization whose CME program has been accredited by AMA.* The "accredited co-sponsor" must be sufficiently involved in the planning, development, administration and evaluation of the program to assure that it meets the definition of a "planned program." The FMA gives Mandatory Credit to any program approved by an accredited co-sponsor for Category 1 Credit.

Thus "Mandatory Credit" is strictly an FMA term. It includes:

- (1) CME activities reviewed in advance and specifically approved by the FMA Committee on Continuing Medical Education through its Subcommittee on Program Approval.
- (2) Programs approved by a member's FMA-recognized specialty society.
- (3) Offerings previously designated by an AMA-accredited institution or organization as Category 1.
- (4) Offerings previously designated by an Academy of Family Physicians for Prescribed Credit.

The reader should be aware that while FMA routinely accepts as Mandatory Credit any AAFP Prescribed Credit or AMA Category 1 Credit, the reverse is not true. Program directors who have received Mandatory Credit for an activity and who want also Prescribed or Category 1, must apply separately to the Academy of Family Physicians or to an AMA-accredited co-sponsor, whichever is appropriate.

V. - How to Calculate Mandatory Credit

It is recommended that each FMA member subject to the CME requirements establish a separate file for records of his CME activities. Into this file would go printed programs of meetings he has attended, certificates of attendance or completion of courses, and informal notations on courses attended, and journal reading and other unsupervised activities. A file that is kept up-to-date

conscientiously will save a great deal of time, reliance on memory and telephone calls to course sponsors when the time comes for the physician to file his Continuing Medical Education Reporting Form. With all this information assembled in one place, his secretary can review the file and fill out the form in a relatively short time. It is strongly suggested that the physician preserve a copy of the printed program for all meetings he attends. It is helpful to underscore credit hours available and check or underline sessions actually attended.

A log for recording attendance at other activities for which a printed program is not available and for such elective hours as journal reading, listening to tapes, etc., also is a useful part of the file. And what would be a safer, easy-to-find repository for *this informational pamphlet* than the CME file?

Here's a list of common CME activities for which members may earn credit:

1. *Activities approved for AAFP Prescribed Credit and/or AMA Category 1 Credit* - Hour-for-hour to maximum approved for program. No limit to number of hours that may be reported on Continuing Medical Education Reporting Form (76PF-142).
2. *Activities approved for Mandatory Credit by FMA Committee on Continuing Medical Education* - Hour-for-hour to maximum approved for program. No limit to number of hours that may be reported on Form 76PF-142.
3. *Activities with no apparent accreditation (in-state and out-of-state)* - Will be accepted for Mandatory Credit upon the recommendation of the appropriate FMA-recognized specialty group.
4. *AMA or FMA-approved residency, internship, fellowship, or research* - Maximum of 50 hours of Mandatory Credit for a full year; pro rata share for shorter periods.
5. *Mini-Residency* - Hour-for-hour Mandatory Credit to a maximum of 30 hours (or 50% of the three-year requirement) for any *one* mini-residency. Up to 30 Mandatory hours additional may be claimed for a second mini-residency taken within the same cycle.

*The FMA Committee on Continuing Medical Education acts as the AMA's agent in accrediting hospitals, county medical societies, specialty organizations in Florida. A list of AMA-accredited institutions and organizations is available from FMA Headquarters in Jacksonville.

6. *Medical Teaching* - If teaching position is approved by the AMA, FMA, AAFP, or one of Florida's medical schools, up to 30 hours of Mandatory Credit (or 50% of the three-year requirement) may be earned. Instructional material should be oriented *primarily* toward physicians.
7. *Tapes and other audiovisual programs approved for Prescribed, Category 1, or Mandatory Credit* - Up to 30 hours (or 50% of the three-year requirement) may be earned. Members should be aware that most such programs can be reported only for Elective Credit.

VI. - How to Calculate Elective Credit

In general, physicians may report Elective Credit for participating in CME activities not otherwise approved for Mandatory, Prescribed or Category 1.

Both the FMA and the AAFP apply the term "Elective" to CME activities that do not meet the criteria for FMA Mandatory or AAFP Prescribed Credit. However, there is a great deal of variation between the two organizations' definitions of "Elective." In the AAFP program, the test involves the questions of whether the CME program under review is relevant to family practice, and whether there is participation in the planning by some level of the Academy or a medical school through its Department of Family Practice. If the answer is negative, the Elective designation usually is applied. With these criteria, it is obvious that some programs designated as Elective by AAFP may meet the requirements for FMA Mandatory or AMA Category 1 Credit.

AMA does not use the term "Elective" with regard to activities that are not Category 1. Instead it has established five other categories:

Category 2 - CME activities with non-accredited sponsorship

Category 3 - Medical teaching

Category 4 - Papers, books, publications and exhibits

**Category 5* - Non-supervised individual CME activities

Category 6 - Other meritorious learning experiences

Many CME activities that would be credited in AMA Categories 2, 3, 4, 5, and 6 might be eligible for FMA Mandatory Credit. For example, the FMA Committee on Continuing Medical Education specifically approves many non-Category 1 programs that would be reported to AMA in Category 2. And certain medical teaching, included in AMA Category 3, is accepted for FMA Mandatory Credit, as we have seen. Following are some examples of CME activities that should be reported to FMA as Elective Credit:

1. *Meetings and conferences not otherwise approved for Mandatory, Prescribed or Category 1 Credit* - These would include many county medical society scientific sessions, hospital staff conferences, etc. However, *no credit may be claimed for participation in or attending medical society or hospital staff business meetings.*
2. *Teaching* - When the instructional material is geared *primarily* to the needs of nurses and other allied health personnel, credit should be claimed in the Elective category.
3. *Scientific Exhibits* - Up to 10 Elective hours may be claimed for preparation of a scientific exhibit designed for viewing by professional audiences. Credit may be claimed only once for any one exhibit. Physicians may also claim Elective Credit for viewing and studying scientific exhibits. For example, a physician who spends an hour at a medical meeting touring the exhibits and talking with exhibitors about the exhibits may claim one hour of Elective Credit.
4. *Papers, Publications and Books* - Ten Elective hours may be claimed for each paper, publication or text book chapter that is authored and published for professional readership. A paper for which credit is claimed must be published in a recognized journal. Credit may not be claimed under this provision for any work for which credit for teaching also is claimed. Medical editing alone cannot be accepted for credit.
5. *Self-instruction* - Elective Credit may be claimed for journal reading, self-

*Category 5 is further divided into the following subcategories: (A) Self-Instruction (B) Consultation; (C) Patient Care Review; (D) Self Assessment; and (E) Preparation for Specialty Board Examinations.

instruction, programmed instruction, viewing medical motion pictures, listening to tapes, etc., that are not otherwise approved for Category 1, Prescribed or Mandatory Credit.

6. *Consultation* - The education a physician receives from a consultant is reportable credit. The instructional period should not be less than one hour, nor can more than one hour be claimed for any one consultation. The consultant himself may claim credit for medical teaching.
7. *Patient Care Review* - Credit is available for the educational value of participation in programs concerned with review and evaluation of patient care. This includes such activities as peer review, medical audit, consecutive case conferences, chart audit, utilization review, and participation in a Professional Standards Review Organization (PSRO), where participation involves patient care review, or the development of screening criteria.
8. *Self-assessment* - Self-assessment examinations which are graded confidentially and which help the physician identify his areas of weakness are creditable.

A reminder: No more than 90 elective hours may be included in the triennial 150-hour requirement.

VII. - Role of the Specialty Society In the CME Program

The FMA-recognized specialty society is uniquely qualified to play an important role in the Association's CME program.

First, the FMA program does not directly address the physician's individual CME needs. The program is flexible and the FMA does not require that orthopedic surgeons, for example, concentrate their CME efforts within that specialty.

This is where the specialty society can perform a useful service. It may, if it wishes, specify what part of a member's 150-hour requirement must be within that specialty. For example, a specialty society might require that its members obtain 20 of the required 60 mandatory hours in their specialty area,

another 20 hours in areas directly related to the specialty, and the remaining 20 hours in areas of the members' own choosing.

What about the physician who belongs to two or more FMA-recognized specialty groups? Does he have to meet the requirements of all the societies to which he belongs?

No. He may choose himself which criteria he will follow.

Specialty societies which elect to adopt criteria beyond those of FMA must collect and evaluate members' CME Reporting Forms prior to forwarding them on to the appropriate county medical societies.

The specialty society also provides a program review service for the CME program. Many CME activities held both in Florida and outside the State have no apparent approval by AMA, AAFP or FMA. When a physician wishes to claim Mandatory Credit for such an offering, he should consult the appropriate FMA-recognized specialty society to determine whether it meets its criteria.

VIII. - Method of Reporting

Generally speaking, each member subject to the CME requirements should fill out a Continuing Medical Education Reporting Form (Form 76PF-142) at the end of his three-year cycle.

However, *active members* of the Florida Academy of Family Physicians need not do this. The FAFP headquarters will notify county medical societies immediately when its members have met the FAFP study requirements for re-election to the Academy. Members of the Academy in classifications *other than active* must file the Form 76PF-142.

Physicians who use the AMA Physician's Recognition Award to fulfill the FMA requirement need only enclose a copy of their PRA in their Form 76PF-142. They need not itemize their CME activities.

All others should itemize the activities for which they claim credit in the "Mandatory" and "Elective" sections of the form, as appropriate. Care should be taken to list titles of all activities or courses, locations, sponsors, dates and amount of credit claimed for each entry. Reporting is on the honor system; however, it is recommended that members preserve any documentation of attendance available in case county medical societies call for it.

Reports, when completed, should be sent to the member's county medical society, *not to FMA*.

Physicians who are members of FMA-recognized specialty societies *that have adopted additional CME criteria* must send their Forms 76PF-142 to the specialty society for evaluation. Members of societies *that have not adopted additional criteria* may send their Forms 76PF-142 directly to their county medical societies.

In either case, Form 76PF-142 must be delivered to the county medical society by January 31 following completion of the member's three-year cycle.

Each county medical society has developed its own procedure for checking completed Forms 76PF-142. Members who wish to know how their county medical societies handle these reports should inquire of the societies directly.

By March 1 of each year, each county medical society must report to the FMA Committee on Continuing Medical Education only the names of members who have satisfied the CME requirements for the preceding three-year cycle. Subsequently, appropriate certificates of completion will be issued jointly by the county medical societies and the FMA.

Starting March 1, 1979, county medical societies will include in these reports to FMA the names of members who have not met the CME requirements. Also, they will notify delinquent members in writing.

IX. - More About Cycles

There are three three-year cycles, each overlapping the other by one or two years. They are called Cycle 1, Cycle 2, and Cycle 3. Each member retains the same cycle number during his entire career with FMA unless he is recycled because of illness, temporary retirement or for some other reason. Following is a table of cycles for the next several years:

CYCLE 1	CYCLE 2	CYCLE 3
1974-76	1975-77	1976-78
1977-79	1978-80	1979-81
1980-82	1981-83	1982-84
1983-85	1984-86	1985-87
1986-88	1987-89	1988-90

X. - Penalties and Appeals

Members who without sufficient justification fail to meet the CME requirements are subject to suspension from the Florida Medical Association and their county medical societies. The FMA Board of Governors will sit in final judgment on whether a member will be suspended.

A physician who disagrees with a delinquency finding by his county medical society may appeal first to the society. The appeal must be in writing and properly documented.

If the physician disagrees with the appellate decision of his county medical society, he may appeal further to the FMA Committee on Continuing Medical Education. The decision of the CME Committee is appealable to the FMA Board of Governors.

XI. - Make-up of Delinquent Credits

Each physician who is designated by his county medical society as being delinquent in his CME requirement will have the calendar year immediately following his three-year cycle to make up credits. However, his next three-year cycle commences with the beginning of the grace period. *Delinquent credits made up during this period may not also be applied to the new three-year cycle.*

Example: Dr. DeLay reports only 40 Mandatory hours (he must have at least 60) for the three-year cycle ended on December 31, 1978. He is given calendar year 1979 to make up the 20 hours he is deficient. During 1979 Dr. DeLay earns 35 hours of Mandatory Credit. Twenty of these are applied to the previous cycle to make up the deficiency. The remaining 15, and only those 15, are reported for the new three-year cycle beginning on January 1, 1979.

XII. - Exemptions and Extensions

Physicians who have legitimate reasons such as disability, illness, reduction in practice, etc., may apply to the FMA Committee on Continuing Medical Education for exemption, reduction in required hours, or extension of cycle, whichever is appropriate. The request should be made on Form 76MF-197 (Application for Individual Exception to FMA Continuing Medical Education Requirements), which is available from the FMA Headquarters.

Upon receipt of a completed form 76MF-197, FMA will forward it to the member's county medical society for recommendation. The request, along with the county medical society's recommendation, will be forwarded to the Committee on Continuing Medical Education's Subcommittee on Exemptions and Extensions for disposition.

XIII. - Medical Education Number

In addition to Social Security and all sorts of other numbers, each physician also has a *Medical Education Number*. This should be entered on a member's Continuing Medical Education Reporting Form and other forms used by the FMA Committee on Continuing Medical Education. A physician may locate his Medical Education Number by consulting his listing in "Roster 1—Members by Component Societies and Specialties" in the current issue of *The Florida Medical Directory*.

The ME Number, consisting of 11 digits (arranged as: 000-00-00-0000), appears under the physician's name along with other numbers. There is a key immediately preceding Roster 1 that explains which numbers constitute the ME Number and what the grouping signifies.

XIV. - Any Questions?

It is hoped that this booklet has answered any and all questions you had in mind about the Florida Medical Association's Continuing Medical Education Program for members. If you have a question that has not been answered to your satisfaction, please feel free to address it to:

Committee on Continuing Medical Education
Florida Medical Association, Inc.

Post Office Box 2411
Jacksonville, Florida 32203
Telephone: (904) 356-1571

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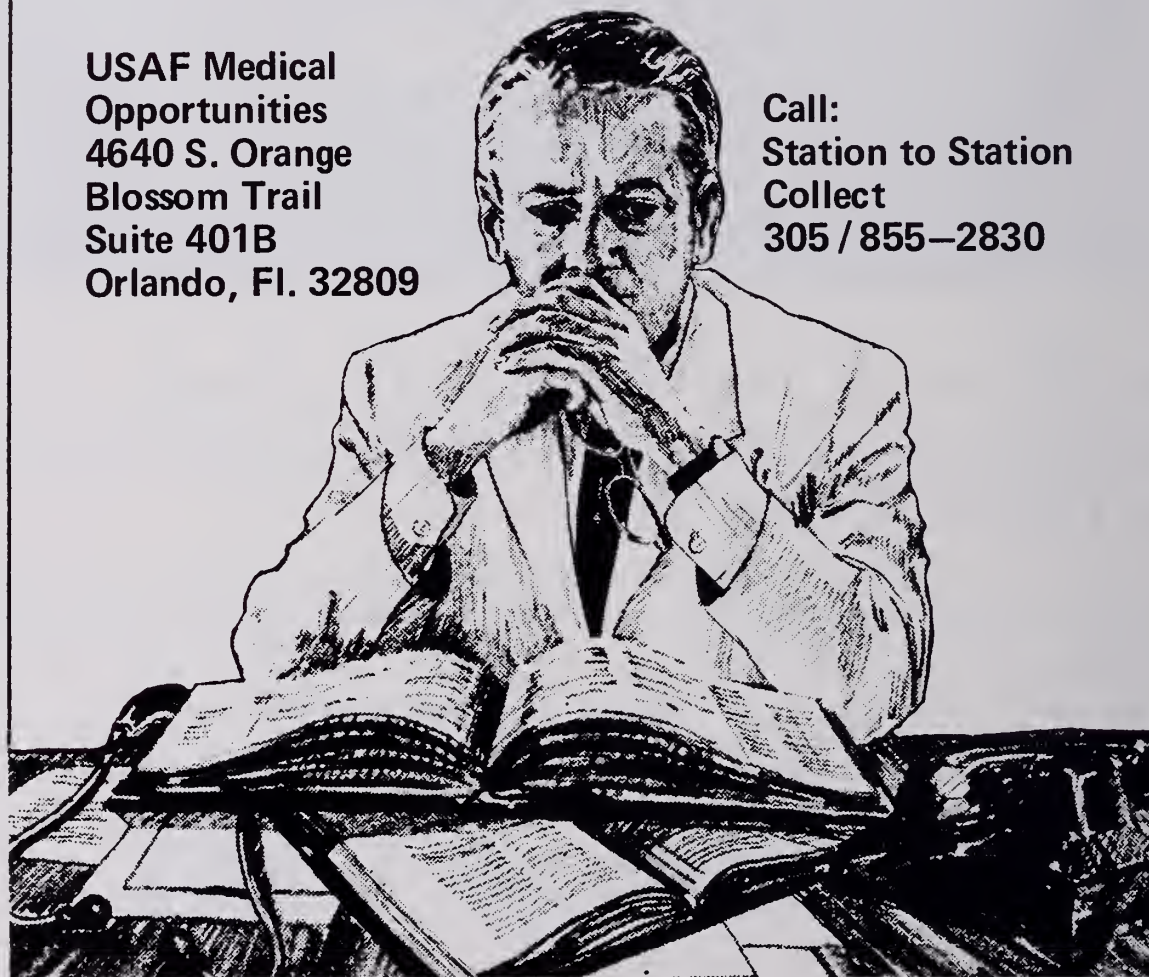
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FLORIDA MEDICAL ASSOCIATION, INC.



103rd Annual Meeting

May 4 - 8, 1977

at the Americana Hotel, Bal Harbour, Florida

FMA General Session
President's Guest Speaker
William F. Buckley, Jr.



Americana Hotel



Auxiliary / FLAMPAC
Luncheon Guest Speaker
Richard M. Scammon



FMA Dinner Dance
Jerry Marshall Orchestra



Special Guest Star
Scotty Plummer
"The Prince of Banjo"

Highlights of the 1977 FMA Annual Meeting

The 103rd Annual Meeting of the Florida Medical Association, scheduled May 4-8, 1977 at the Americana Hotel, Bal Harbour, will feature not only an expanded scientific program, but also two highly respected speakers, and superlative entertainment.

Thirty-five scientific sections and special audio-visual programs offering up to 20 hours of continuing medical education credit were outlined in the March issue of **The Journal of the FMA**.

"Abel S. Baldwin Lecture", Friday, May 6, 1977 — Medallion Room - 11:00 a.m.

Mr. William F. Buckley, Jr., will deliver the "Abel S. Baldwin Lecture" as the guest speaker of FMA President Jack A. MaCris, M.D., at the FMA General Session beginning at 11:00 a.m., Friday, May 6. Mr. Buckley, who gained national prominence in 1965 when he campaigned for the office of Mayor of New York City, is the founder of **National Review** and the author of the nationally syndicated column, "On the Right". He is also the host of "Firing Line", a TV talk show featuring notable personalities from all over the world which is seen on Public Broadcasting Service stations as well as commercial television stations.

FMA Auxiliary-FLAMPAC Luncheon, Friday, May 6, 1977 — Bal Masque 12:15 p.m.

Mr. Richard M. Scammon will be the guest speaker at the Annual FMA Auxiliary/FLAMPAC Luncheon, slated for 12:15 p.m., Friday, May 6. As an analyst and researcher of the American voter and the American political system, Mr. Scammon most recently served as election consultant for NBC News. He has held a number of Presidential appointments including service as Director of the United States Bureau of the Census. He is also the author and editor of several scholarly volumes dealing with the American voter, including the 11-volume series, **American Votes**.

FMA Dinner Dance

Due to the highly successful dinner dance held in conjunction with last year's Annual Meeting, there will be a dinner dance for all FMA members and their guests at 7:30 p.m. on Friday, May 6, 1977, immediately following the President's Reception. The cost is \$25.00 per person which includes dinner and all entertainment. (Children under 12-years-old, \$15.00).

DOOR PRIZES — A special added treat for this year's dance will be the awarding of a number of fabulous door prizes, which will include full size framed Caduceus print by noted Florida artist, Lee Adams, donated by the Florida Medical Foundation (valued at over \$300.00).

RESERVATIONS — Advance reservations may be obtained by filling out the form on the bottom of this page and returning it to FMA Headquarters. Tables may be reserved in your name for you and your guests.

Special Guest Star — Scotty Plummer

If you have never heard the amazing talents of young Scotty Plummer, you are in for a delightful surprise. The teenage musical virtuoso will be the highlight of the FMA Dinner-Dance beginning at 7:30 p.m., Friday, May 6.

Scotty Plummer has been hailed as the "Prince of the Banjo", and has lived up to the lofty title in every one of his performances. He has appeared on the Johnny Carson Show, the Mike Douglas Show, the Merv Griffin Show and the Dinah Shore Show, plus a number of television productions and nationally released movies. In live concerts across the country and in Canada, it is quite common for the audience to bring him back on stage for several encores.

Music by The Jerry Marshall Orchestra

For those of you who attended the 1976 Annual Meeting, it should come as no surprise that Jerry Marshall, one of Florida's best known "society band leaders," will again provide superlative entertainment for the FMA Dinner-Dance.

Marshall, with four different bands under his direction, is a musical arranger, a talent coach, and has traveled all over the country performing for various corporations and such famous stars as Burt Bacharach, Tony Bennett and Joel Grey.

Marshall owns the enviable sixth sense of perceiving exactly what each audience wants to hear and blending those desires into unanimous pleasing performances.

— Prices Include Tax and Gratuity —

Please send me advance tickets for the following FMA Annual Meeting Functions:

- (1) FMA Auxiliary and FLAMPAC Luncheon — Friday, May 6, 1977 at 12:15 p.m. (\$10.00 per plate)

Please make _____ reservations @ \$10.00 each Amt.

- (2) FMA Dinner Dance — Friday, May 6, 1977 at 7:30 p.m. (\$25.00 per plate) (Children under 12, \$15.00)

Please make _____ reservations @ \$25.00 each Amt. _____ Please make _____ reservations @ \$15.00 each Amt. _____

Enclosed is my check for the total amount of \$ _____

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Please mail completed form to Florida Medical Association, Inc., Post Office Box 2411, Jacksonville, Florida 32203 (Annual Meeting)



ORGANIZATION

Florida Endocrine Society Plans Two Scientific Sections

The Florida Endocrine Society has announced plans to co-sponsor, with the Florida Medical Association, two scientific sections during the 103rd Annual Meeting of FMA. Both will be conducted on Friday, May 6, at the Americana Hotel in Bal Harbour.

Lawrence M. Fishman, M.D., Program Chairman for the Endocrine Society, said the morning session will be devoted to "Problems of Reproductive Endocrinology." The afternoon program will be entitled, "Endocrine-Related Cancer."

The entire Annual Meeting Scientific Program is acceptable for 20 hours of AMA Category 1 Credit and FMA Mandatory Credit. An additional hour will be available to physicians who complete a pharmacology self-assessment questionnaire sponsored by the University of Florida.

Members of the American Academy of Family Physicians may earn AAFP Prescribed Credit by attending the Section on Family Practice on Thursday afternoon, May 5 (4 hours); the Section on Nuclear Medicine and Family Practice on Friday morning (2¾ hours); the four Dialogue programs on Friday morning and Friday afternoon (1 hour each); and by taking programmed instruction on the Auto-Tutor (1 hour per offering).

FRIDAY MORNING - MAY 6

SECTION ON ENDOCRINOLOGY SECTION I

(Co-sponsored by Florida Endocrine Society)

Friday—8:15 a.m. to 10:45 a.m.

Lawrence M. Fishman, M.D., Miami
Program Chairman

"Problems of Reproductive Endocrinology"

"Abnormalities of Sexual Differentiation," William W. Cleveland, M.D., Professor and Chairman, Department of Pediatrics, University of Miami School of Medicine, Miami

"Evaluation of Amenorrhea," William J. LeMaire, M.D., Professor of Obstetrics and Gynecology, University of Miami School of Medicine, Miami

"Male Hypogonadism," Mortimer D. Lipsett, M.D., Director, Clinical Center, National Institutes of Health, Bethesda, Md.

Discussion

Adjournment

FRIDAY AFTERNOON - MAY 6

SECTION ON ENDOCRINOLOGY SECTION II

(Co-sponsored by Florida Endocrine Society)

Friday—2:00 p.m. to 5:00 p.m.

Lawrence M. Fishman, M.D., Miami
Program Chairman

"Endocrine-Related Cancer"

"Estrogens and Cancer," Mortimer D. Lipsett, M.D., Director, Clinical Center, National Institutes of Health, Bethesda, Md.

Discussion

"Evaluation and Management of the Patient with a History of Radiation to the Head and Neck," Robert B. Katims, M.D., Clinical Professor of Medicine, University of Miami School of Medicine, Miami

Discussion

Case Presentations

Adjournment



Book Reviews

Book Review Editor

F. Norman Vickers, M.D.

Malpractice Made Easy — Can You Believe That? by Alan R. Rosenberg, M.D., J.D., F.C.L.M. and Lee S. Goldsmith, M.D., LL.B., F.C.L.M. 170 pages. Price (not stated). Magazines for Industry, Inc., New York, 1976.

Since the authors have both medical and law degrees, I was curious to know which way this book would go — whether it would be a treatise for patients on how easy it is to sue doctors for malpractice, or an explanation of the pitfalls of the law which makes it so easy for doctors to be sued. The mystery was cleared up in the very first sentence of the Preface, "The purpose of this book is to provide doctors with a simple, yet comprehensive, grasp of the major operative elements of law as it applies to malpractice and their practice." It is the authors' contention that if practicing doctors better understood the medicolegal problems which face them in their practice, they could assess their own problems fairly accurately and reduce their chances of running afoul of malpractic traps. But too few books have been written on the subject of medical law purely for physicians in readily comprehensible language, the authors contend. With this in mind, they have undertaken to write this small, nearly pocket-size book of 170 pages in basic, brief, concise and comprehensible English, and "not overboundened with legalese."

Whether this purpose has been accomplished is open to question in my mind. True, the book covers the majority of common medicolegal problems in 29 chapters, each chapter exploring and explaining a separate phase of medical law. Some chapters are concise and clearly written; others are less clear. The chapter on abortions is completely out of date in view of the recent U.S. Supreme Court decisions on abortions on demand and the right of a wife to have an abortion without her husband's consent or a minor child to do likewise without parental consent.

Despite some shortcomings, I found the book very informative and easy to read, and it would be

well worth the little time it would take for physicians to read it; however, I doubt whether any physician whose horoscope forecasts a malpractice suit sometime in the future will be able to avoid it by becoming learned in the contents of this little volume.

Franklin J. Evans, M.D., LL.B.
Coral Gables

Dr. Evans is in the private practice of Family Medicine in Coral Gables. He also holds a law degree and was a founder-member of the American Board of Legal Medicine and the American Medico-Legal Society.

Principles of Clinical Electrocardiography, Ninth Edition, by Mervin J. Goldman. 412 pages. Price \$9.50. Los Altos, California, Lange Medical Publications, 1976.

Professor Goldman's book, now in its ninth edition, is a time tested handbook of electrocardiography. Not intended as an indepth text of electrocardiography, it distills into crystal clear paragraphs and tables what more voluminous works require chapters to say. This is its strong point, a quick reference that helps solve 95 per cent of the problems the electrocardiographer encounters. While the text and illustrations of this new edition are largely the same as in the previous edition, there are added chapters on cardiac pacing and defibrillation and more blank pages at the back of the book to permit recording of notes. The writer enthusiastically recommends this book to the medical intern, the resident and fellow in cardiology, and to the internist who must read electrocardiograms. For these it will serve as a reliable ready reference and a guide to books and articles which provide a more expanded discussion of individual subjects.

William M. Straight, M.D.
Miami

Dr. Straight is in the private practice of Internal Medicine in Miami.

Books Received

Receipt of the following books is acknowledged. Medical readers interested in reviewing particular books are invited to address requests to the Book Review Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.

Social Responsibility: Journalism, Law, Medicine, Volume II, edited by Louis W. Hodges. 104 Pages. Price \$2.50. Washington and Lee University, Lexington, Virginia, 1976.

A Laboratory Manual for Rural Tropical Hospitals by Monica Cheesbrough and John MacArthur. 209 Pages. Illustrated. Price \$7.50. Churchill Livingstone, New York, 1976.

Current Medical Diagnosis & Treatment, 16th Revision, by Marcus A. Krupp, M.D. and Milton J. Chatton, M.D. 1,066 Pages. Price \$16.00. Lange Medical Publications, Los Altos, Calif., 1977.

Correlative Neuroanatomy & Functional Neurology, 16th Edition by Joseph G. Chusid, M.D. 448 Pages. Illustrated. Price \$10.00. Los Altos, California, Lange Medical Publications, 1976.

Current Pediatric Diagnosis and Treatment, 4th Edition, by C. Henry Kempe, M.D., Henry K. Silver, M.D. and Donough O'Brien, M.D. 1,053 Pages. Illustrated. Price \$15.00. Los Altos, California, Lange Medical Publications, 1976.

Nuclear Energy and National Security by the Research and Policy Committee of the Committee for Economic Development. 80 Pages. Illustrated. Price \$2.50 paperbound, \$4 hardbound. New York, Committee for Economic Development, 1976.

Current Obstetric & Gynecologic Diagnosis & Treatment by Ralph C. Benson, M.D. and Associate Authors. 912 Pages. Price \$16.00. Lange Medical Publications, Los Altos, Calif., 1976.

Growth, Maturation, and Aging by Tadayoshi Imalzumi. 118 Pages. Sugiyama-ku, Tokyo, Kugayama Press, 1976.

The Water Jump—The Story of Transatlantic Flight by David Beaty. 304 Pages. 140 Illustrations. Price \$10.00. Harper & Row, Publishers, Inc., New York, 1977.

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Letters to the Editor

David R. Taxdal, M.D.
222 E. Central Avenue
Winter Haven, Florida

Re: Driggers vs. Taxdal

Dear Dr. Taxdal:

The purpose of this letter is to apologize for my filing suit in behalf of Jill Driggers against you.

At the time, I thought my actions were appropriate based on what my clients told me. There remained only a few days before the statute of limitations was to have run. I did not have an opportunity to investigate the case as well as I should have done. In retrospect, I wish I had investigated further before filing suit.

Soon after filing suit and taking the depositions of appropriate medical witnesses, it was abundantly clear that you were not only free from any negligence but that your treatment of Jill Driggers had accomplished an exceptionally good recovery for her. After taking the depositions, I should have dismissed the suit against you and apologized at

that time. My failure to do so at that time was a mistake on my part for which I sincerely apologize. I compounded my error by continuing with the suit and not dismissing it until just before the Mediation Hearing.

I ask your forgiveness for these errors of judgment on my part. You may publish this apology in any publication you think appropriate to right any damage that may have resulted to you or your reputation as a result of the suit.

Very truly yours,

David A. Graham
Attorney at Law
Fort Lauderdale

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CPT-4 (CURRENT PROCEDURAL TERMINOLOGY, 4TH EDITION) AVAILABLE FROM THE AMA. ORDER YOUR COPY TODAY. PRICE \$12.00. SEND ORDERS TO: ORDER DEPARTMENT, A12, American Medical Association, 535 North Dearborn St., Chicago, Illinois 60610.

Yank D. Coble Jr., M.D., of Jacksonville ... has been elected Chairman of the Florida Diabetes Advisory Council.

E. Charlton Prather, M.D., of Tallahassee, Florida's Health Program Director, was elected Secretary during the Council's organizational meeting on February 26.

Gerold L. Schiebler, M.D., of Gainesville ... Editor of *The Journal*, is among several physicians appointed by Governor Askew to serve on the Florida Developmental Disabilities Planning Council. Jaime L. Frias, M.D., of Gainesville has been officially designated as his alternate.

Other FMA members on the Council are E. Charlton Prather, M.D., Tallahassee; B. J. Wilder, M.D., Gainesville; Julia R. St. Petery, M.D., Tallahassee; and Robert F. Stempfel Jr., M.D., of Miami.

The Council's function is to make recommendations to the Governor and Department of Health and Rehabilitative Services regarding services to people with retardation, epilepsy, autism, learning disorders and other developmental disabilities. It also is responsible for the allocation of funds authorized under Public Law 94-103.



Patricia P. Berry, M.D., a resident in Internal Medicine at the University of South Florida College of Medicine, helps **Robert G. Nelson, M.D.**, display the Nelson Award, given annually to the University of South Florida medical student who exhibits excellence in obstetrics and gynecology. Dr. Berry was the second recipient of the award. The first was **Randy Armstrong, M.D.**, (right), now a third-year resident under **James M. Ingram, M.D.**, (left), Professor and Chairman of Obstetrics and Gynecology at the University of South Florida. Dr. Nelson practiced obstetrics and gynecology in Tampa for 25 years before retiring in 1973.

MEETINGS

Approved by FMA Committee on Continuing Medical Education

MAY

Florida Medical Association 103rd Annual Meeting, May 4-8, Americana Hotel, Miami Beach.

Master Approach to Cardiovascular Problems, May 5-7, The Contemporary Hotel, Walt Disney World**

The Problem of Hand Injuries, May 9, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M. D., 511 West Highland Boulevard, Inverness 32650.

Respiratory Disease, May 11, Beaches Hospital, Jacksonville. For information: K. Ioannides, M. D., 1430 16th Ave., South, Jacksonville 32250.

Asymptomatic Coronary Artery Disease: Early Detection and Management, May 12-14, Innisbrook Resort, Tarpon Springs**

Diagnosis, Evaluation, & Management of Lymphoma, May 13, V. A. Center, Bay Pines. For information: Henry F. Burke, M. D., Chief of Staff, V. A. Center, Bay Pines 33504.

Death-Autopsy Conference, May 17, Lake Shore Hospital, Lake City. For information: J. F. Kazmierski, M. D., P. O. Box 1989, Lake City 32055.

Fifth Family Practice Review, May 23-27, Hilton Hotel, Gainesville**

Cardiovascular Diseases: Diagnosis and Treatment, May 27, Beaches Hospital, Jacksonville. For information: Kyriakos Ioannides, M. D., 1430 16th Avenue, South, Jacksonville 32250.

JUNE

Anesthesia Seminar, June 4, Casino Motel, Pensacola. For information: Warren D. Sears, M. D., 1717 North E. Street, Pensacola 32501.

1977 Physicians' Seminar on Respiratory Disease, June 10-12, Turtle Inn, Atlantic Beach. For information: Iftikhar Ahmad, M.D., P.O. Box 8127, Jacksonville 32211.

Florida Suncoast Pediatric Conference, Second Annual Meeting, June 12-15, Sheraton Sand-Key, Clearwater Beach. For information: Donald MacDonald, M.D., 1510 Barry St., Clearwater 33516.

Twenty Eighth Annual Scientific Assembly, June 22-26, Sandpiper Bay, Port St. Lucie. For information: Florida Academy of Family Physicians, 4057 Carmichael Avenue, Jacksonville 32207.

Postgraduate Seminar in Respiration and Respiratory Care, June 24-26, Americana Hotel, Miami Beach. For information: Frank Moya, M. D., 4300 Alton Road, Miami Beach 33140.

Seminar For Intensive and Critical Care Personnel, June 24-26, Americana Hotel, Miami Beach. For information: Frank Moya, M. D., 4300 Alton Road, Miami Beach 33140.

Post Assembly Seminar, June 26-July 3, Snow Mass, Colorado. For information: Florida Academy of Family Physicians, 4057 Carmichael Avenue, Jacksonville 32207.

JULY

The Problem of Infertility, July 11, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge, M.D., 511 W. Highland Blvd., Inverness 32650.

SEPTEMBER

Tips, Tricks, Traps and Techniques, Sept. 9-11, Sea Turtle Inn, Jacksonville Beach. For information: Duke H. Scott, M.D., 1205 Beach Boulevard, Jacksonville Beach 32250.

The Problem of Microscopic Hematuria, Sept. 12, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge, M.D., 511 W. Highland Blvd., Inverness 32650.

Fourth Annual Comprehensive Review Course in Anesthesiology, Sept. 15-18, Americana Hotel, Miami Beach. For information: Frank Moya, M. D., 4300 Alton Road, Miami Beach 33140.

25th Annual Diabetes Seminar, Sept. 30-Oct. 2, St. Petersburg. For information: Robert Miller, M. D., 1547 San Marco Boulevard, Jacksonville 32207.

OCTOBER

Immunologic and Pharmacologic Advances in Diagnosis and Treatment of Allergic Illness, Oct. 21, Theron A. Ebel, M. D., USF College of Medicine, Tampa 33620.

NOVEMBER

The Problem of Glaucoma, Nov. 14, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge, M.D., 511 W. Highland Blvd., Inverness 32650.

DECEMBER

Sixth Annual Refresher Lecture Course For Nurse Anesthetists, Dec. 2-4, Americana Hotel, Miami Beach. For information: Frank Moya, M. D., 4300 Alton Road, Miami Beach 33140.

*For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152, Tel. (305) 547-6716.

**For Information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143.

+For Information: Contact Theron A. Ebel, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2074.

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MIAMI, FLORIDA: G.P. — Seven man multispecialty, fee-for-service group is seeking a G.P. to join the group. Contact S. L. Weiss, M.D. or Eli Galitz, M.D., 1025 E. 25th St., Hialeah, Florida 33013. Phone (305) 696-0842.

SPECIALISTS

INTERNIST, UROLOGIST, GP's.: Outstanding opportunities in progressive nonurban community serving 20,000. Write John H. Parker, M.D., Chief of Staff, Doctors Memorial Hospital, Perry, Florida 32347.

MIAMI, FLORIDA AREA: Multispecialty group fee-for-service group seeking full or part time Orthopedic Surgeon to join group. Contact S. L. Weiss, M.D. or Eli Galitz, M.D., 1025 E. 25th St., Hialeah, Florida 33013. Phone (305) 696-0842.

PEDIATRICIAN: Board eligible or certified to join two pediatricians in busy central Florida. Excellent opportunity. Beautiful area with excellent hospitals and good schools, near recreation areas. Send curriculum vitae to C-766, P.O. Box 2411, Jacksonville, Florida 32203.

WANTED: An associate for a noncardiac thoracic, cardiovascular and general surgeon. American graduate preferred. Florida license required. West Palm Beach, Florida area. Send resume to: C-789, P.O. Box 2411, Jacksonville, Florida 32203.

ORTHOPEDIC SURGEON, DERMATOLOGIST. Immediate openings. Private solo practices. Liberal financial assistance including guaranteed income and free rent for first year. Attractive community, good schools. Contact Claude L. Weeks, Ex. Dir., Flagler Hospital, P.O. Box 100, St. Augustine, Florida 32804. (904) 824-8411.

PEDIATRICIAN. To join 10 doctor multispecialty clinic in Winter Haven, Polk County, Florida. Salary first year, then partnership and percentage. 400 bed hospital one block. Board certified or eligible. Contact Bill Brigman, Administrator, Bond Clinic. 601 First Street North, Winter Haven, Florida 33880. Phone: (813) 293-1191.

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CONFERENCES FOR MEDICAL PROFESSIONALS. A calendar listing of over 500 national/international meetings, conferences and seminars in the medical sciences for 1977. All medical specialties included. Send a \$10.00 check or money order payable to Professional Calendars, P.O. Box 40083, Washington, D. C. 20016.

PHYSICIAN AND SONOGRAPHER TRAINING PROGRAM. All aspects of Diagnostic Ultrasound will be covered including how to start and operate an Ultrasound Department. One month physician program with three months and one year sonographer programs for qualified persons. Special arrangements may be considered. Limited number of applicants accepted. For further information phone or write: J. J. Crittenden, M.D., Diagnostic Ultrasound Department, West Florida Hospital and Clinic, 8383 North Davis Highway, Pensacola, Florida 32504. Phone (904) 478-4460, Ext. 174.

FAMILY PRACTITIONER OR INTERNIST wanted to share facilities with five practitioners in solo practice. Major equipment provided. Rent \$250.00 per month. Excellent laboratory and x-ray with income based on use. Bookkeeping system shared. Financial assistance available to the right party. Contact: T. C. Kenaston, Jr., M.D., Box 550, Cocoa, Florida 32922.

WANTED: Physician to join several other physicians in emergency room practice in central Florida community hospital, 150 beds. Forty hour week. Benefits include 3 weeks vacation and 2 paid medical conferences. Starting salary \$40,000 yearly. Must be graduate of U.S. medical school, have AMA internship, and some previous practice desirable. Florida license necessary. Contact: James N. Kulpan, Administrator, Waterman Memorial Hospital, P.O. Drawer B, Eustis, Florida 32726. Phone: (904) 357-4161.

MEDICAL AND SURGICAL DIRECTOR: Florida's Department of Offender Rehabilitation has a position open for a Florida licensed physician, preferably with 4-5 years administrative experience managing a health delivery system composed of several institutions. Salary: \$33,700-47,938 depending on qualifications. Write or call: Office of the Recruiting Coordinator, Department of Offender Rehabilitation, 1311 Winewood Boulevard, Tallahassee, Florida 32301. Phone: (904) 488-3130.

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Situations Wanted

INTERNIST—CARDIOLOGIST, University trained in non-invasive cardiology including echocardiography—right heart catheterization. Seeks full time position in hospital based or group practice. Write C-751, P.O. Box 2411, Jacksonville, Florida 32203.

THIRTY SIX YEAR OLD FEMALE PHYSICIAN with rotating internship, 1 year medical residency, working towards family practice boards, desires position as associate or assistant to family practitioner, in the Miami area. Write C-779, P.O. Box 2411, Jacksonville, Florida 32203.

GENERAL SURGERY—POSITION WANTED: 33, married, amiable and versatile, seeking group, partnership, or solo opportunity, southern Florida. Finishing 5 year university training program. Available July 1. Curriculum vitae on request. Eugene I. Sacks, 450 Walton Road, Maplewood, New Jersey 07040. Phone: (201) 763-5312.

OB/GYN BOARD ELIGIBLE, Flex and Florida license, seeks solo, partnership or group. Available July 1, 1977. 12 years experience in Ob/Gyn. Contact Marcos Lara, M.D., 355 Bard Avenue, Apt. 5R, Staten Island, New York 10310. Phone (212) 390-1538.

CARDIOLOGIST—FLORIDA LICENSED—desires hospital based, group or solo practice. University trained in clinical cardiology, noninvasive techniques (echocardiography—right heart catheterization). Currently director of CCU. Available July 1977. Write C-775, P.O. Box 2411, Jacksonville, Florida 32203.

GENERAL SURGEON, American university trained. Age 30. Completed training one year ago. Significant vascular experience. Seeks position in coastal community. B. Haicken, Mt. Horeb Rd., Martinsville, New Jersey 00836. Phone: (201) 469-5739.

PSYCHIATRIST; BOARD ELIGIBLE: education at Upstate Medical Center—Syracuse, N. Y. Experience in social and community psychiatry, research, teaching and consultation. Florida license eligible. Fluent in Spanish. Write C-788, P.O. Box 2411, Jacksonville, Florida 32203.

GENERAL AND VASCULAR SURGEON, age 34, married, 5 years University training, board certified, Florida license, seeks association with another surgeon—single or multi-specialty group. Write C-773, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST, 32, certified in pulmonary medicine wishes to relocate. Experienced in academic hospital based patient care, licensed in Florida. Prefers West coast; will consider offers from hospitals, groups or quality internists for association. Write C-781, P.O. Box 2411, Jacksonville, Florida 32203.

30 YEAR OLD MALE GENERAL SURGEON, good experience peripheral vascular surgery available July 1977. Partnership, group or solo practice. Contact: D. Mobed, M.D., 80 Guion Place, New Rochelle, New York 10801.

CARDIOTHORACIC SURGEON, university trained, open-heart, coronary bypass and valvular surgery. Florida licensed. Seeks position with established group. Write C-785, P.O. Box 2411, Jacksonville, Florida 32203.

PEDIATRICIAN, 39, American, seeking salaried position either clinic or hospital based. Languages include Spanish, Italian. Available June 1st. Write C-733, P.O. Box 2411, Jacksonville, Florida 32203.

YOUNG, BOARD ELIGIBLE, FLORIDA LICENSED, GENERAL SURGEON, looking for position for July 1977. Now completing one year pediatric surgery fellowship. Two years surgical experience in Air Force. Prefer group practice or partnership in community near larger city. Contact: Clifford A. Lakin, M.D., 24 Archdale Street, Charleston, South Carolina 29401. Phone: (803) 577-5384.

INTERNIST-SUBSPECIALTY ALLERGY, board certified in both, Florida license, American graduate, ten years practice experience, desires group or solo practice. Write C-767, P.O. Box 2411, Jacksonville, Florida 32203.

PATHOLOGIST, PH.D. (not M.D.) 33, desires position in research, teaching or other suitable work. Well experienced also in microbiology. Available summer 1977. Write 7320 Biscayne Boulevard, Miami, Florida 33138.

ANESTHESIOLOGIST available from August '77. Board eligible on July 31, 1977. Possessing a Florida license. Over five years experience in anesthesiology. Experience in England also. Write C-783, P.O. Box 2411, Jacksonville, Florida 32203.

PATHOLOGIST, 32, wife pediatrician, both university trained, FLEX licensed in Illinois and board qualified, desire suitable placement in Florida. Available July 1977. Contact: Dr. Bala, 526 Maple Lane, Darien, Illinois 60559. Phone: (312) 963-2133.

CARDIOLOGIST, BOARD CERTIFIED, 35, experienced in clinical cardiology and noninvasive techniques. Seeks association, group or hospital practice. Knowledge Spanish. Write C-793, P.O. Box 2411, Jacksonville, Florida 32203.

ORTHOPEDIC SURGEON, 30, married, university trained, available July 1978. Experienced in total joint replacement, desires partnership, group, or solo on Florida coast. American, Bilingual, Spanish-English. Write C-794, P.O. Box 2411, Jacksonville, Florida 32203.

OPTOMETRIST: 35 + years experience in visual analysis, refraction and contact lenses desires association with ophthalmologist in Southern Florida full or part time. Write: Dr. Wm. J. Freedman, 1715 Washtenaw Ave., Ypsilanti, Michigan 48197. Phone: 1-313-483-2100.

INTERNIST: 30, board eligible, American graduate, seeks practice opportunity in Florida, available 7/77. Write: C. J. Lupu, M.D., 732 Carter St., Rochester, New York 14621.

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PHYSICIAN RETIRING: TAKE OVER PRACTICE in July 1977, fast growing area of S. W. Florida. Three hospitals in area. Write C-790, P.O. Box 2411, Jacksonville, Florida 32203.

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FOR SALE: ONE 15' BAHAMIAN SAILING DINGHY—fibreglass, teakwood fittings, sail and carrying trailer, \$900; one Sajou's Encyclopedia of Medicine—a rare antique book collection; one Pelton Steam Autoclave; one Picker x-ray Unit, 300 ma, 125 pkv. 90/15 tilt table, fluoroscope, spot film device, floor to ceiling tube stand with electromagnetic locks, videx collimator, electronic bucky, 12/1 grid, one General Electric x-ray unit, 200 MA-100 VP, Full wave rectification, two tube Rad/Flu, Model KX-11, tilt table. Contact Alex Trombly (813) 253-2667, 8:00 - 5:00.

FOR SALE: Used (excellent condition) Sanborn EKG machine with walnut table plus all equipment. Microscope, Edison tape recorder—metal 2 step for exercise test. Make offer. Write C-791, P.O. Box 2411, Jacksonville, Florida 32203.

Real Estate

OUTSTANDING LOCATION FOR SPECIALIST: St. Nicholas Medical Center. Central location, off street parking and all utilities furnished (including janitor service). Contact W. G. Allen Jr., Owner-Manager, St. Nicholas Medical Center, 3127 Atlantic Boulevard, Jacksonville 32207. Phone (904) 398-5500.

ST. PETERSBURG: Pasadena Medical-Dental Building, 419 Pasadena Avenue South. New deluxe office building. Just minutes from Palms of Pasadena and St. Petersburg General Hospitals. Custom designed for your needs. For complete information call Gerald F. Dalrymple (813) 866-2474.

FOR SALE—FORT LAUDERDALE AREA: Real Estate practice and equipment. 3,000 sq. ft. office—2,000 sq. ft. apartment well equipped for family practice. Canal front. Write C-770, P.O. Box 2411, Jacksonville, Florida 32203.

FOR SALE: 275 acres parklike, peaceful mountain property, gently sloped, near Wilkesboro, N.C. Interior roads. Timber. Conveniences close. Price \$137,500. Terms. Other tracts available. Wiegand Real Estate, P.O. Box 423, Conway, S.C. 29526. Phone (803) 365-5545.

MEDICAL OFFICE AVAILABLE for one year lease with option to buy in fast growing, very busy suburban Orlando, Florida. Experienced office manager, receptionist will remain upon request. Medical files of community still in possession for takeover. Available April 1. A. R. Kovats, M.D., 4848 Silver Star Road, Orlando, Florida 32808. Phone (305) 299-4681 from 9 to 6 on Mondays, Wednesdays and Fridays. Home phone: 894-2567.

LAKELAND, FLORIDA: FOR SALE, 6% down. Air-conditioned office for one to three physicians. Main street, 168 x 140 ft.; double parking lots; extra cottage. Dr. L. Polskin, Box 15966, Honolulu, Hawaii 96815.

OFFICE FOR RENT: fast growing area on S.W. Florida coast available July. Three hospitals in area. Write C-790, P.O. Box 2411, Jacksonville, Florida 32203.

OFFICE AVAILABLE IN PLANTATION prestigious Jacaranda area: New, furnished, available immediately, 1,000 sq. ft. office in busy medical complex. Lease full or part time. Phone: (305) 583-4858.

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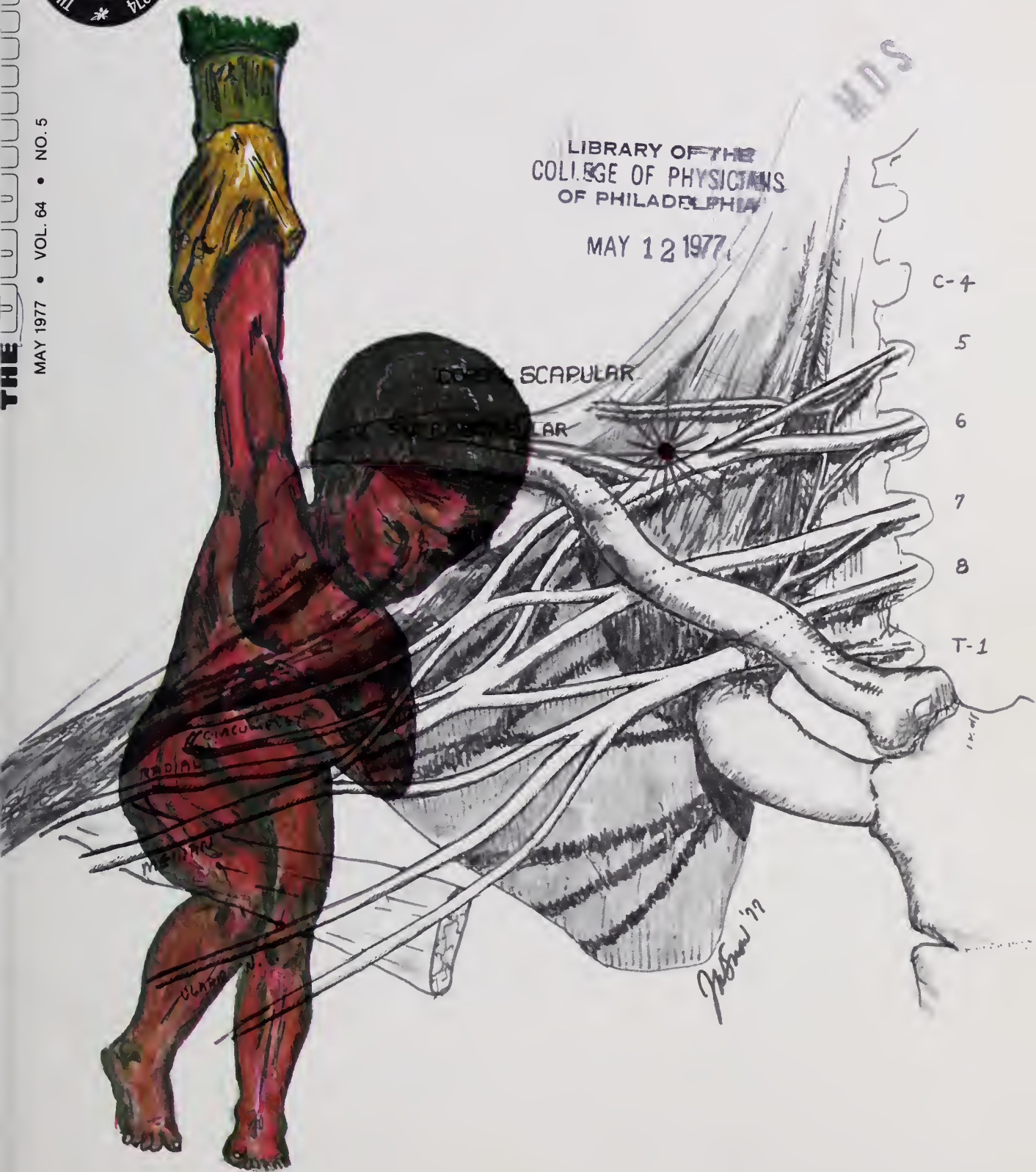
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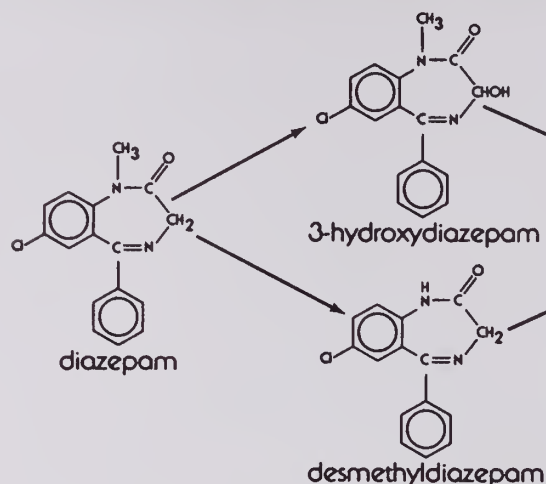


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may be used in patients with open angle glaucoma who are receiving appropriate therapy.

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MAY COVER—We are most grateful to John W. Snow, M.D., of Jacksonville, for this month's cover showing a somewhat expanded view of the brachial plexus and Erb's point where it is frequently injured during a forceful delivery.



President's Page

Congressional Visitation

Each spring the Florida Medical Association conducts a congressional visitation so that the key contact physicians of the legislators and Florida Medical Association officers may visit all of the Florida congressmen in their offices in Washington, D.C. This affords a unique opportunity for Florida physicians to transmit the thoughts of "grass roots" practicing doctors to those men who vote for us in the Senate and the House. Both medical and non-medical topics are discussed in the informal, relaxed conversational atmosphere of the congressmen's office in contrast to the formal hearings at which we physicians, as representatives of organized medicine, are sometimes invited to testify. This visit is capped by a strictly social luncheon for the legislators at which no business is discussed — medical or legislative.

This was my first opportunity to participate in one of the twenty-six annual pilgrimages, and it was an interesting experience. Besides the excitement of again seeing our nation's Capitol, and the impressive buildings which house our government's too numerous activities, I was surprised at the interest shown in our visit by our legislators. Although our visits were scheduled for thirty minutes each, some of the conversations lasted as long as an hour and a half. I am convinced such exchanges of ideas promote better legislative action over the long pull.

One comment made by several legislators, and confirmed by their office personnel, was the importance of individual letters sent to them by voters. They seemed eager to examine arguments on both sides of legislative questions to help them reach a position. When their mail is sorted in their respective offices, the "mass request" type of communications are lumped together, while the individual letters are usually read and considered separately.

Also of interest was the opportunity to be on the scene when a bit of history was being made. During our visitation the Common Site Picketing bill was defeated in a House vote much to everyone's surprise. This was credited primarily to the "mass request" type of letters and postcards sent in by working people who would be directly affected by the bill.

Thus, both the individual letter and the "mass request" influence legislation. We must continue to voice our views individually and collectively in the political arenas, local, state and national.

This being my final President's Page, I wish to thank all of my colleagues who have given of their time and effort on behalf of the Florida Medical Association. It is their service that keeps the organization viable and effective serving our patients and our profession. I also wish to thank you all for the opportunity of serving this year in what has been the most enriching experience of my professional life.

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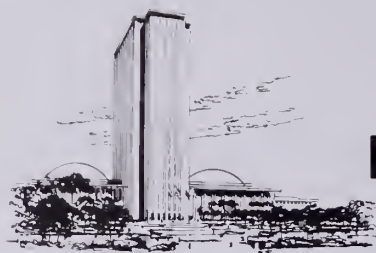
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LEGISLATIVE NEWS

Annual Washington Visitation — The annual visitation of FMA congressional key contact physicians was held March 23-24. The visitation program, presented Florida physicians with an opportunity to meet face to face with the Florida congressional delegation and discuss with them pertinent issues of concern to Florida physicians. An extensive briefing for the group was conducted by the AMA Office on Wednesday afternoon, and individual appointments were scheduled with each Congressman on Wednesday and Thursday. Concluding the visitation was a luncheon in the Speaker's Dining Room, presided over by FMA President Jack MaCris, M.D. Key issues discussed with the delegation were status of national health insurance legislation, HSA's, PSRO, and legislation relating to Medicare/Medicaid fraud. Each member of the Florida delegation was visited and urged to support the FMA position for enactment of catastrophic coverage only with comprehensive coverage for the medically indigent, urged to oppose extension of the authority for HSA's and PSROs and made aware of concerns about sections of the Medicare and Medicaid fraud and abuse bill which would require PSROs to become enforcement agencies of the Department of HEW and sections of the same legislation which would make most physician group practices subject to the cumbersome reporting and records availability requirements of the bill.

Certificate of Need — With the backing of the Department of HRS, Florida's State Health Coordinating Council and Gov. Reubin Askew, legislation has been filed which would revise Florida's certificate of need law and expand its scope to include, among other things, selected items of equipment in physicians' offices. The Association has been actively working with members of the Legislature and their staffs to insure

that adequate consideration is given to the many problems proposed by this concept.

Federal law requires that by fiscal year 1980, each state must have on its books certificate of need legislation which meets the requirements of rules and regulations adopted by the Department of HEW. If appropriate legislation is not enacted, substantial federal funding in the public health area would be lost. Without question, Florida's certificate of need law has had many benefits and in many incidences has prevented the building of unnecessary beds in hospitals throughout the state. Concurrent with the benefits, however, has been a pattern of denial of needed hospital and medical equipment in many facilities. In addition, the process through which a certificate of need must flow is extremely cumbersome and expensive for Florida's health care institutions.

On January 31, 1976, professors at Johns Hopkins and Washington University, through contact with the Department of HEW, rendered a report on the impact of state certificate of need laws on health care costs and utilization. This report concluded that:

"The results of this analysis indicate that Certificate of Need (CON) controlling guidelines reduced expansion in beds, but increased expansion in plant assets per bed, and had no discernible negative effect on total investment (change in total plant assets). In other words, CON regulations altered the composition of investment but not its magnitude, discouraging new beds but encouraging investment in new equipment and services . . .

In summary, our analysis points to the (perhaps), surprising conclusion that CON controls have contributed to cost inflation; thus, they have tended to produce the very result which they were designed to prevent. This conclusion must, of course, be treated

cautiously due to the limitations of the analyses on which it is based . . . At a minimum, our findings signal the need for a much more thorough and detailed study of the effectiveness of CON regulation as a cost-control device. The presumption of its effectiveness is clearly not warranted by the available evidence."

Detailed analysis of the legislation indicates more stringent requirements being proposed in Florida than required by the Federal regulations as follows:

1. Federal regulations do not require expansion of certificate of need to equipment in physicians' offices. The Florida proposal would apply certificate of need to acquisition and operation of radiation therapy units, CAT scanners, and cardiac catheterization labs.

2. The Federal requirement necessitates a certificate of need when there is an increase in hospital beds by more than 40, or 25% of bed total, whichever is less, in a two-year period. The current Florida law requires a certificate of need for the addition or decrease of any number of beds in existing or new facilities.

3. Federal requirements call for certificate of need for expenditures in excess of \$150,000, whereas the Florida proposal requires for the

certificate of need for expenditures in excess of \$100,000.

4. The Florida proposal requires a certificate of need for purchase of an existing health care facility whereas the Federal requirements do not go into this area.

5. The proposed Florida law, also contrary to Federal requirements, calls for a statement of income and expenses on a pro forma basis for the first two years of operation (which would include equipment in physician's office) and requires a statement of cost containment benefits to be derived from the public by the accomplishment of the proposed project.

6. The Florida proposal also gives preferential treatment to HMOs.

It is most unfortunate that the drafters and promoters of the proposed certificate of need legislation do not anywhere in the legislation take into consideration the medical needs of a community in determination of a certificate of need. Cost of purchase and utilization of services and facilities are certainly important, but it is most inconceivable that Florida's citizens desire this type of governmental control and regulation without appropriate consideration being given to medical necessity and the quality of health care in the State.

"National Influenza Immunization Program"

County health directors have received a communication from the Director of the Center for Disease Control in Atlanta regarding the unused supplies of A/New Jersey vaccine. County health departments were advised to contact all private physicians and other outside providers who were issued influenza vaccine. These providers are to be notified that all opened and/or partially used vials should be discarded appropriately and all unopened vials should be returned to the county health department. The collection process should begin by May 2 and completed no later than May 16, 1977. Any questions concerning this procedure should be directed to the county health department.

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Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

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Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

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Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



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FROM THE EDITOR'S DESK

HEW ERRS

The American Medical Association has uncovered numerous errors in the government's list of physicians who received \$100,000 or more in Medicare payments in 1975. In March, the Department of HEW revealed the names of 409 physicians, 1,752 medical groups and 58 laboratories which it said received the payments. Of the first 112 physicians checked by AMA only 32 were correct as listed. One doctor who was said to be practicing in Illinois and having received \$233,871 from Medicare in 1975, actually has been in retirement in Arizona for 12 years, the AMA discovered. Another physician on the list had died in 1974. Said one FMA staff member: The HEW list "has got to be one of the sloppiest performances in the history of American bureaucracy."

* * * *

RESIDENT SEEKS AMA POST

William J. Mangold Jr., M.D., J.D., has become the first resident physician to declare his candidacy for the AMA Board of Trustees. Dr. Mangold, 33, has been endorsed by AMA's Resident Physicians Section. He received his law degree in 1969 from the University of Texas Law School, and his M.D. degree in 1973 from the University of Texas Medical School. At the present, he is a surgical resident at the East Virginia Graduate School of Medicine, Norfolk, Va. Election of trustees will take place in San Francisco at the AMA Annual Convention in June.

* * * *

COMPUTER CONSULTING SERVICE

Physician response to the new AMA computer consulting service has been encouraging. For a daily fixed fee plus expenses, a specialist will make an on-site visit to a physician's office to assess his practice needs and offer recommendations on office computer assistance.

* * * *

RULING CRITICIZED

A federal court dismissal of AMA's suit challenging the Department of HEW's Maximum Allowable Cost drug program has been criticized by AMA Board Chairman Raymond T. Holden, M.D. "This can only have an adverse effect on patient care," he said. The MAC Program limits reimbursement for certain drugs under Medicare and Medicaid to the lowest-cost generic form available. The ruling against AMA was handed down in Chicago by Judge Prentice Marshall.

* * * *

MODEL BILLS

AMA is distributing to state medical associations for possible consideration by their state legislatures model bills on acupuncture and clinical laboratory billing information. The first bill provides that acupuncture is an experimental procedure to be performed only in a research setting by a licensed physician or under his direct supervision. The clinical laboratory bill would provide for needed information on medical bills and would assist in preventing potential abuse in billing practices.

* * * *

AUXILIARY PROJECTS

More than 300 projects undertaken by medical society auxiliaries all over the country are contained in the AMA Auxiliary Project Bank. The bank contains summaries of each project for others who might wish to undertake a similar one. Information is available from the AMA Auxiliary, AMA Headquarters, 535 N. Dearborn St., Chicago, Ill. 60610.

* * * *

The Editor

Testand-B tablets



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Dean's Page

Provision of a Single High Standard of Care to Patients at the University of Miami-Jackson Memorial Hospital Medical Center

E. M. Papper, M.D.

On March 9, 1977, the Public Health Trust of Dade County submitted to the Health Systems Agency an application for a Certificate of Need for the construction of a facility at the University of Miami-Jackson Memorial Medical Center. The new facility will update and improve programs for emergency, obstetrical, pediatric, gynecologic, gynecologic/oncology services, as well as our clinical and anatomical laboratories. The construction of this facility will permit demolition of the remaining substandard facilities and accomplish the geographic integration of care to patients in all programs at Jackson Memorial Hospital. This program, labeled Phase II of the Jackson Memorial Construction Program, is the result of more than three years of intensive planning efforts on the part of the Public Health Trust, the School of Medicine of the University of Miami, the Dade County Board of Commissioners, the Medical Center staff and Master Planning consultants. During the process the goal of the Public Health Trust has focused on two major areas of concern:

1. The elimination of deteriorated and scattered facilities which hinder the efficient delivery of service and which do not allow for provision of a single high standard of care;

2. The development of Medical Center programs which do meet the needs of the community and fill the assigned role of the Trust as a **major tertiary referral center**.

The program has had constant input from our local Health Systems Agency. The HSA spent over a

year studying the role of the Medical Center. During the past five years it has also produced planning guidelines calling for decentralized health services in primary care, emergency room, and obstetrics. The Health Systems Agency has made our community aware of the need to carefully evaluate the number of acute hospital beds required for Dade County. Accordingly, it does not wish to see the Medical Center add to the overbedded situation.

Because of the input of the Health Systems Agency, several specific changes in the Phase II program have evolved:-

1. An overall plan to reduce the number of beds in the Medical Center from 1320 to 1250.

2. Integration of the University of Miami Hospital and Clinics/National Children's Cardiac Hospital into the overall Jackson Memorial Hospital bed plan while the new tower is being constructed. At the conclusion of construction, it is the intent of the School of Medicine to close its inpatient services at the UMHC, thus reflecting an honest attempt on the part of the Public Health Trust and the School of Medicine to reduce beds in the Medical Center and at the same time place the management of health facilities under the Public Health Trust in the Medical Center.

3. Improvement in the services provided by the Jackson Memorial Hospital Emergency Center. This reflects the commitment to the HSA's Emergency Services guidelines calling for regionalization.

4. Improvement in the efficiency and responsiveness of the clinical laboratories which are presently operating in outdated and insufficient space.

Dr. Papper is Vice President for Medical Affairs and Dean, University of Miami School of Medicine, Miami.

5. Reduction in deliveries from 6,000 to 4,500 reflecting the Health Systems Agency's obstetrical guidelines calling for decentralization of routine deliveries.

6. A shift to tertiary emphasis as reflected by increase in the rehabilitation, intensive care, and cancer programs which support decentralization of secondary services.

7. The University of Miami and the Public Health Trust are considering the future governance of the Anne Bates Leach Eye Hospital as set forth in our affiliation agreement.

8. Finally, a further degree of flexibility to reduce beds from the 1250 bed capacity after the tower is completed, if for any reasons demands for inpatient services at Jackson are reduced in the future.

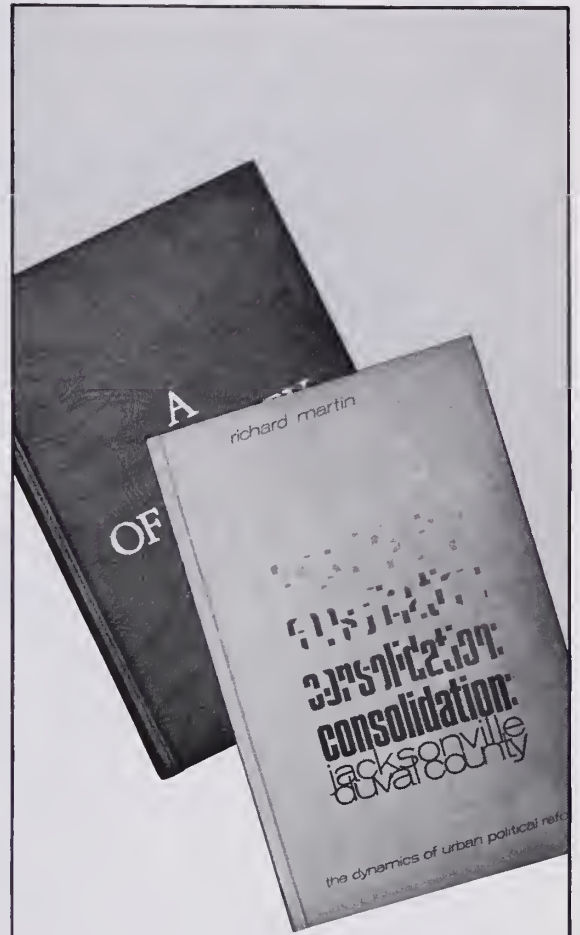
We feel certain that the application for a Certificate of Need for the construction of a patient care tower to include an emergency room, laboratory, perinatal center, pediatric and gynecologic services will be favorably reviewed and approved by the Review Committee and the Board of Directors of the Health Systems Agency because of the importance of this major Medical Center to South Florida. We are convinced that this program is in the best interest of Dade County and South Florida. Moreover, we believe that this action strongly re-emphasizes our commitment to tertiary care and provides an efficient backup system for the community's overall health care programs. It is only through the coordinated efforts between the Health Systems Agency and the health professions that the burgeoning costs, the unjustifiable duplication, and the inconveniences to patients can be minimized and placed into reasonable perspective.

E. M. Papper, M.D.
Vice President for Medical Affairs
and Dean, School of Medicine

Mr. Fred Cowell
Acting Chief Executive Officer
Public Health Trust

Bernard J. Fogel, M.D.
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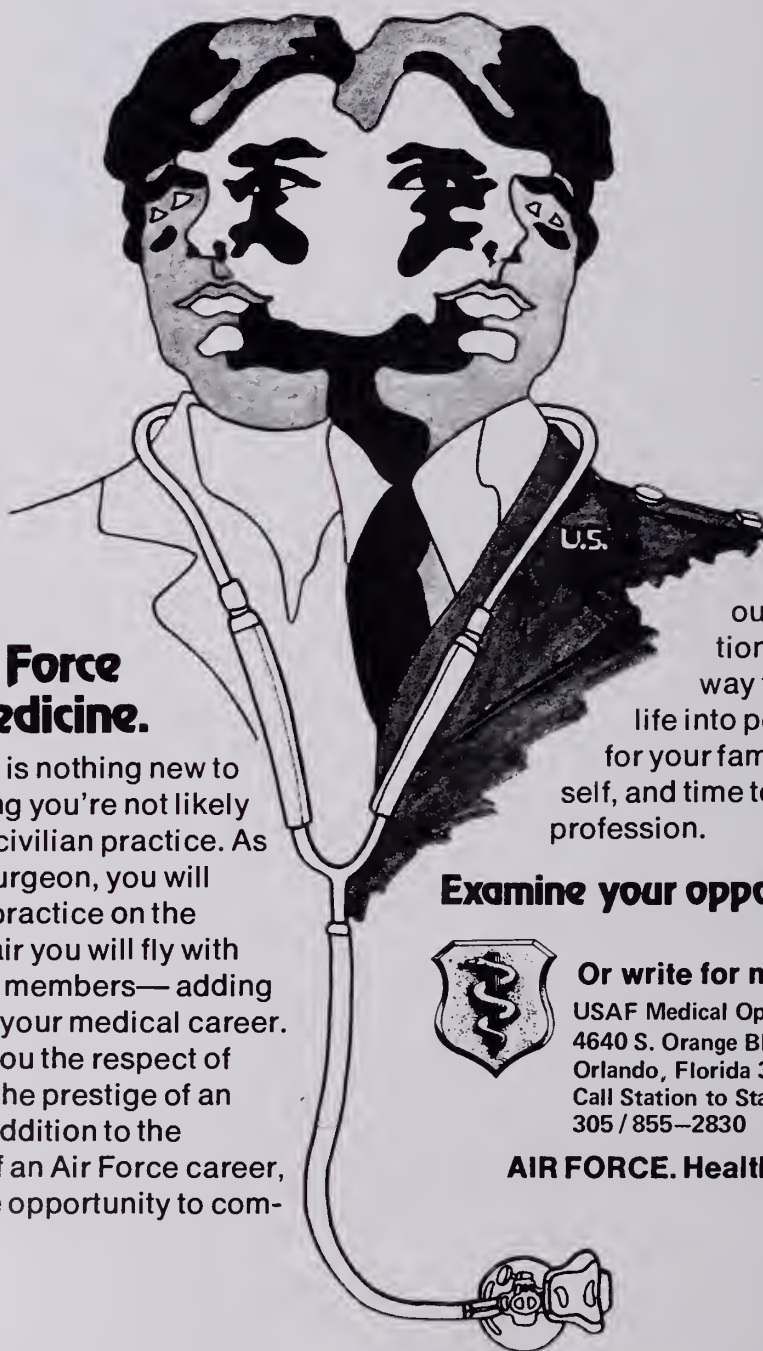
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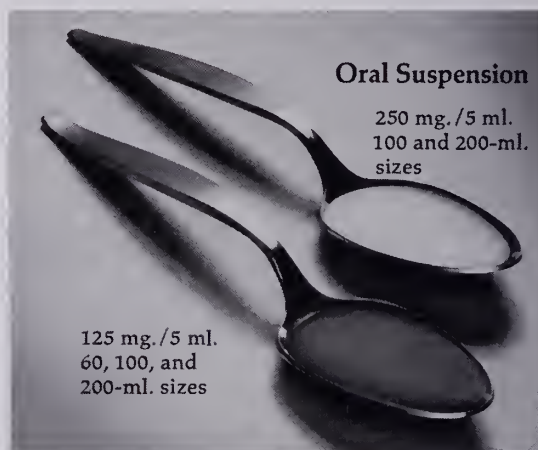
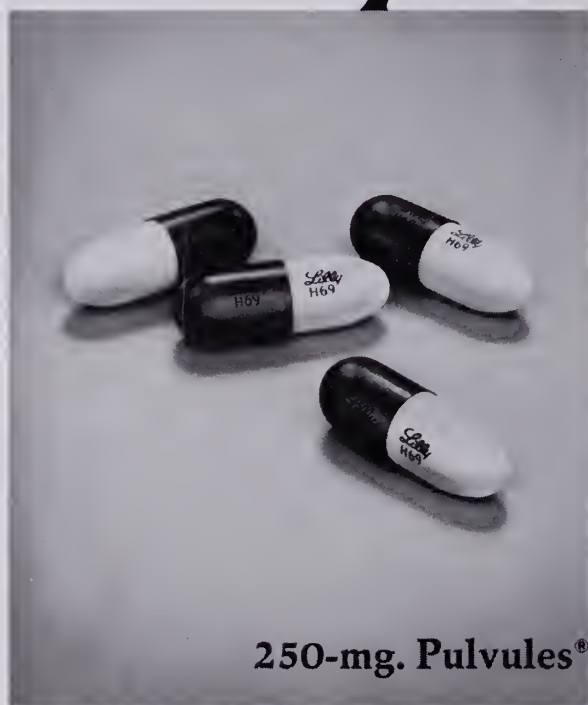
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Shoulder Dislocation in the Infant Case Report and Discussion

Philip O. Lichtblau, M.D.

ABSTRACT: This report was initiated after observing an infant with paralytic shoulder dislocation. The literature has been reviewed and the very rare congenital shoulder dislocation is the main topic of this presentation. Birth paralysis and the concept of birth trauma are first discussed. Dislocation, as will be reported, is probably a secondary condition due to a combination of birth paralysis and the subsequent therapeutic positioning of the arm in abduction and external rotation. Surgical reduction for subcoracoid dislocation may encounter thickening of the inferior capsule or bow-stringing of the long head of the biceps.

Smellie¹ in 1764 was the first to mention paralysis of the arm resulting from injuries to the brachial plexus during delivery. Duchenne² 1872, Erb³ 1874 and Klumpke⁴ in 1885 described the mechanism and site of injury to the nerves producing the types of paralysis now associated with their names.

After the classic description by Clark, Taylor and Prout⁵ in 1905 of their findings during surgical exploration of the plexus, traction became accepted as the mechanism of injury. Kolodny⁶ in 1941 questioned the diagnosis of avulsion because of a well known photograph of an infant that Taylor⁷ described some 20 years previously which was later reproduced in journals many times by other authors. He believed it to be an example of stereotyped information taken for granted by writers

without due criticism. Scaglietti⁸ attempted to prove that in the majority of cases, the lesion does not involve the nerve trunks of the brachial plexus, the trauma being limited to the upper humerus itself.

McFadden⁹ stated that "a voluminous literature has gathered around this little tragedy in the midwife's art. Yet our knowledge is still uncertain. The actual lesion is not definitely accepted. The treatment is unsatisfactory. The injury is undoubtedly produced during the act of delivery and not in utero. The baby delivered by cesarean section does not run the risk of this daily reminder of his birthdate."

Pathogenesis

There is general agreement that trauma inflicted on the child during exit from the birth canal plays the major role. Lesions are associated most frequently with prolonged and difficult labor. In the literature, a large portion of injured children were delivered with forceps. First borns are more frequently affected and breech presentation shows a higher percentage of birth injuries.

In vertex presentation, it is the delivery of the shoulders that causes the problem. The difficulty is usually due to the absence of rotation of the shoulders. To deliver the shoulder, the head is depressed in an attempt to bring the shoulder down under the symphysis and at the same time attempting to do what nature has failed to do, rotate the shoulders by rotating the head. This puts the plexus in the best possible position for traction injury.

There are two divergent concepts regarding the pathology: (1) Direct injury to the component parts

Presented at the annual meeting of the Florida Orthopedic Society, December 8, 1975, Palm Beach, Florida.

of the brachial plexus, and (2) Injury to the shoulder joint structures and capsule with posterior subluxation of the humeral head after birth.

Scaglietti⁸ described the obstetrical shoulder trauma. He believed that in the majority of cases the lesion did not involve the nerve trunks or the brachial plexus. He considered the clinical symptoms after epiphysiolysis to be essentially the same as after obstetrical paralysis, those being functional disability and internal rotation contraction of the arm. He noted that these two essentially different lesions had always been described as one and the same. The x-ray in the early stages of birth shoulder trauma is entirely negative. There are no changes in the upper end of the humerus. The first positive signs appear with the formation of periosteal callus in the form of a cloudy shadow around the upper end of the humerus. Toward the third month, however, when the bony nucleus appears in the head of the humerus, a more precise statement can be made as to whether there was a partial or complete epiphysiolysis with or without displacement of the upper end of the humerus. The exact diagnosis of a traumatic shoulder lesion is of great value. If there is no displacement of the epiphysis, almost complete cure can be expected. If there is displacement, the clinical and roentgenological syndrome of obstetrical shoulder trauma will develop. Scaglietti believed that the cases with displacement do not represent a simple epiphysiolysis but a fracture through the cartilaginous epiphysis which means the separation is above the epiphyseal line. This would explain the absence of hematoma, swelling and periosteal callus formation during the first few weeks after delivery. The primary cause of internal rotation is the defense position that the injured arm assumes; which means the arm is rested against the chest for immobilization and prevention of pain.

Scaglietti reported on 199 cases. He believed that obstetrical joint trauma was the lesion most frequently encountered (53 cases). Wickstrom¹⁰ in 1954 reported on 54 patients with birth injuries of the brachial plexus. No mention was made of birth trauma. In recent communication,¹¹ he stated that he did not believe in the birth trauma theory.

DePalma¹² felt that it was more reasonable to conclude that some cases are the result of direct injury to the brachial plexus with subsequent true paralysis of specific groups of muscles. Others are pseudoparalysis caused by shoulder joint trauma with deformity simulating true paralysis, while still in others, both concepts may be applicable.

Confirmative pathologic studies are scarce in the literature as most of these children, without surgery, lead quite normal lives. There are a few reports of exploration which confirm traction and avulsion theories. Gravelona¹³ was the first to report evidence of damage to the spinal cord in a patient who suffered severe paralysis of the brachial plexus as a result of birth trauma. Wiles¹⁴ stated that in severe injuries, the nerve trunks are ruptured completely as the nerve roots are avulsed from the spinal cord. However, Steindler¹⁵ did not believe that avulsion at the spinal cord could take place. Wickstrom¹⁰ reported on 87 children treated from 1944 to 1958. Fifty-four had 5-6 lesions, 11 had 8-1 lesions and 22 showed involvement of all components. Surgical exploration was not undertaken in any of these children. The severity of damage was estimated by rate of improvement and residual dysfunction in the arm. This is the method most commonly used in studies dealing with the diagnosis, etiology and prognosis of cases of birth shoulder trauma.

In a survey of all x-rays of 29 cases in a local crippled children's program, there was evidence of one possible case of trauma as described by Scaglietti.⁸ The boy is 14 years of age. He was first seen at age seven with excessive internal rotation. At age 14, when the only x-ray was taken (Fig. 1), clinical findings had not changed. He demonstrated 90° of internal rotation and 30° of external rotation. He has always been completely functional and has had no surgical intervention.

In the absence of treatment, deformity develops very rapidly, particularly in the upper arm. Fixed abduction and medial rotation of the shoulder may develop within a matter of days, particularly if there has been concomitant injury to the shoulder joint. Failure of recovery of active abduction and lateral



Figure 1

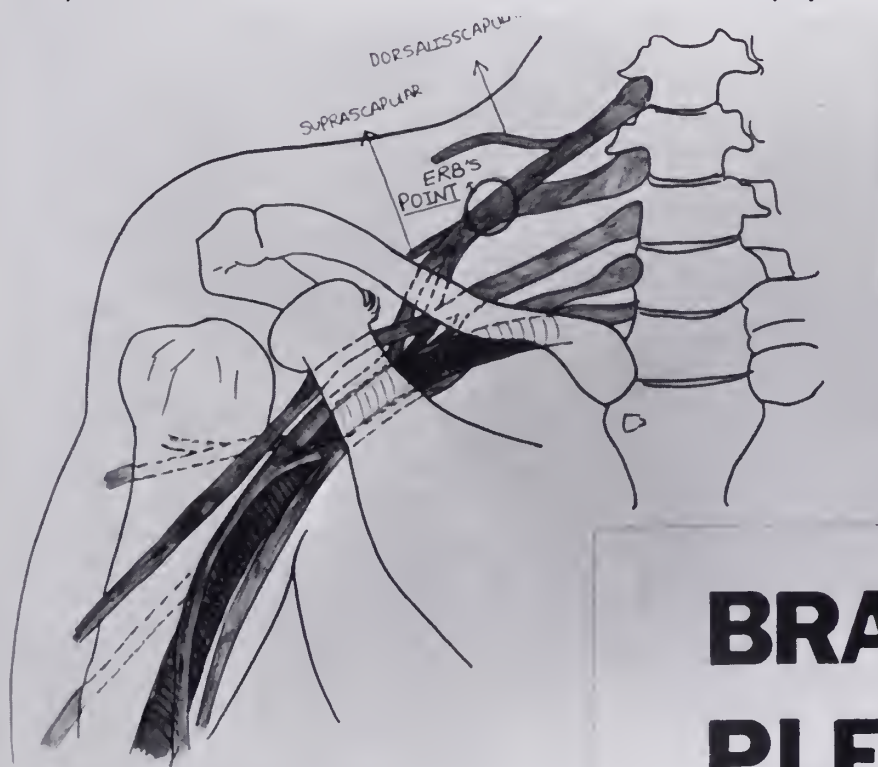
rotation aggravates the deformity and later posterior dislocation of the shoulder may occur. Fairbanks¹⁶ attributed this to immobilization of the shoulder in an abduction splint but Wickstrom¹⁰ believed it was associated with attempts to flex the shoulder in the presence of medial rotation contracture. He found it frequently. The anterior-inferior dislocated shoulder will be the main topic of this presentation.

Anatomy

The brachial plexus (Fig. 2) begins at the lateral border of the scalenus anticus and passes behind the middle third of the clavicle and ends at the lower border of the pectoralis minor (junction of the second and third parts of the axillary artery). The first and second parts of the axillary artery are related to the cords of the plexus and the third part is related to the large nerves springing from the plexus. The axillary artery is the continuation of the subclavian at the outer border of the first rib. Erb's point is at the junction of the 5th and 6th roots forming the upper trunk, at a point after the dorsal scapula and before the suprascapula nerves emerge. An injury at Erb's point should, therefore, preserve function in the supraspinatus and infraspinatus muscles.

There are three types of birth paralysis syndromes:

1. **The Upper Arm or Erb-Duchenne Type.** This lesion is encountered most frequently of the three types. The 5th and 6th cervical roots are involved. A pertinent clinical feature is the lack of sensory disturbances. Such is not the case in lesions implicating the entire plexus in which there is profound sensory loss. Generally with correct management in upper arm palsy, the prognosis for partial or complete recovery is favorable.
2. **The Lower Arm or Klumpke type.** This lesion is rare. It implicates the 8th cervical and first thoracic producing paralysis of the muscles supplied by the ulnar nerve and inner head of the medial nerve. The intrinsic muscles of the hand and the flexors of the forearm were involved. Atrophy of the paralyzed muscles and incomplete closing of the hand occur. Sensory loss is demonstrable in the dermatomes of C-8 and T-1.
3. **The Whole Arm type.** The entire plexus is implicated and flaccid paralysis of the extremity is present with sensory loss. There are many gradations in severity which occur between the upper and whole arm types depending on the extent of the injury and the number of roots affected.



THE THREE CORDS OF THE
BRACHIAL PLEXUS ARE
PLACED AROUND THE
SECOND PART OF THE
AXILLARY ARTERY AND
IN THIS WAY RECEIVE
THEIR NAMES
MEDIAL
LATERAL
POSTERIOR

BRACHIAL PLEXUS

Figure 2

In the newborn, the differential diagnosis, of course, must consider fracture of the clavicle and fracture of the humerus. They have been reported occurring concomitantly.

Incidence

The reason for the gradual decreasing incidence of birth trauma is well known. In essence, it is a reflection on the improvement in obstetrical care. The steady decline is substantiated by statistics. A study at the New York Hospital showed the ratio to be 1.56 per thousand births in 1938 down to .38 per thousand in 1962. At the Hospital for Special Surgery, 491 cases were seen from 1928 to 1939, a period of 11 years; whereas there were only 123 patients from 1939 to 1962, a period covering 23 years.

Of interest are a few figures from a local and state crippled children's program. In 1973, 80 cases were reported in Florida; in 1974, 83 cases and in 1975, 89 cases. Previous records are not available as the state, three years ago, went on the computer and past records have been all but destroyed. In the local crippled children's program involving five counties, we have records of 20 cases. Eleven were diagnosed as Erb's, and nine brachial; 14 were right, and six were left, 14 female and six male. There are nine current cases, five male and four female.

Treatment

Conservative: Sever¹⁷ in 1916 recommended bracing with the Statue of Liberty splinting device (Fig. 3). In 1925 after an experience with 1,100 patients, he retracted this recommendation and



Figure 3

stated that braces delay recovery. Milgram¹⁸ pointed out the definite danger of over immobilization in a position of abduction, stating that abduction contracture of the shoulder was frequent. He noted it in 16 of his 23 patients. Wickstrom modified the protective splint after Milgram reported his concern of it producing an abduction contracture. Wickstrom's splint maintained complete external rotation with forward flexion of 45° and abduction of only 70°. The elbow was flexed to 120°. Frankel, Goldner and Stelling¹⁹ stated that extensive protective splinting in the first 12 to 18 months is not necessary. They felt that prevention of a contracture is usually not completely possible by splinting, stretching or active exercise. They believed that in the face of rapid growth and paralysis of the external rotators the prevention of a contracture was difficult if not impossible.

Surgical treatment is recommended as soon as maximum muscle improvement has occurred and deficiency of the posterior deltoid and external rotators is recognized. Tendon transfers should be accomplished by age three or four years, as at this early period external rotation can be strengthened and frequently joint contracture and subsequent incongruity of the glenohumeral articular surfaces can be prevented.

The time honored operations are: (1) Sever (Myotomy-Capsulotomy). Release of the subscapularis and pectoralis major, (2) L'Episcopo (Tendon Transfer). Teres major and latissimus dorsi to produce external rotation, (3) Putti (Derotation Osteotomy). Above the insertion of the deltoid, and (4) Wickstrom's modification of the Fairbank's procedure for the posteriorly displaced head. Open reduction with sectioning of the subscapularis using a transfixing pin for three to six weeks.

In 1954 Tom Outland²⁰ discussing Wickstrom's paper stated that the L'Episcopo procedure for upper arm lesions was no longer being used. He felt there was good reason for this. An injury of sufficient magnitude to produce the permanent changes of Erb's palsy is not likely to spare the other roots completely. If there is involvement of the hand, the need for finger grasp and thumb opposition is infinitely more important than the need for external rotation of the shoulder and if the former cannot be supplied the condition of the shoulder is not of great practical importance. This severely restricts the number of cases in which transplantation of teres major and latissimus dorsi is indicated.

A finding not too often mentioned is posterior dislocation of the radial head following splinting.

Adler and Patterson²¹ stated that involvement of the elbow in Erb's palsy is not infrequent. There was elbow involvement in 38 of 88 patients. There was a flexion contracture of the elbow in 24 and posterior dislocation of the radial head in 14. A very severe problem was a progressive disruption of the entire elbow joint. They believed this to be most perplexing and had no recommendation as to therapy or prevention.

Congenital Dislocation of the Shoulder

Case Presentation

This is a case of subglenoid dislocation in an infant.

The mother was a 27-year old black; gravida 5, para 4, admitted in labor at term. With pudendal block anesthesia, forceps were used to deliver a baby boy from the LOA position. Shoulder dystocia was present and with moderate difficulty, while the anterior shoulder was delivered, excessive stretching of the neck occurred. Weakness of the right arm and hand were noted at birth. This child was first seen in clinic on 12/13/74 at the age of three months. An orthopedist diagnosed Erb's palsy and ordered an airplane splint to maintain abduction and external rotation. No x-ray had been taken. X-rays were first made two months later on 2/12/75 showing inferior dislocation of the shoulder (Figs. 4A, 4B, 5). He had by then worn the splint six weeks. The mother was advised that the child should have an attempt at manipulation and possibly an open reduction. A URI delayed prompt hospitalization.

On 5/8/75, there was an unsuccessful attempt at an arthrogram and failure of gentle closed reduction. Traction was attempted with the arm at 90° of abduction, this failed (Fig. 6). On 5/13/75 an open reduction was performed.

An anterior approach was used. The subscapularis was released. Portions of the glenohumeral ligaments were incised. Portable x-rays were taken to determine the best position of the arm for continued traction postoperatively. Complete relocation was not possible without releasing the entire inferior and posterior capsular structures. This was not done. The arm was again placed in traction postoperatively (Fig. 7). On 5/18/75 the traction was removed (Fig. 8). On 5/22/75 the child was discharged from the hospital with the arm in a valpeau in mild abduction.

On 5/28/75 a recheck x-ray showed the head to be not well located (Fig. 9). The arm was held in abduction of 70°. It was felt that with gravity, activity, and adaption, a better glenohumeral relationship would develop. There was good elbow and hand function all along. On 6/20/75 we noted clinical improvement (Fig. 10). The x-rays still showed a degree of anterior displacement of the humeral head (Fig. 11). On 10/17/75 there was further improvement both clinically (Figs. 12-14) and by x-ray (Fig. 15). He was last seen on 11/14/75 at age 14 months and six months postoperative demonstrating function approximating normal.

Discussion

A search of the literature disclosed two other reports of congenital dislocation of the shoulder. In

1953 Liebolt and Furey²² described a case of dislocation of the shoulder six months after an obstetrical paralysis. An x-ray taken the day of birth showed paralysis of the arm but no shoulder abnormality. The shoulder was immobilized in 90° of abduction and 90° of external rotation. At six months the child was noted to have an obvious dislocation of the shoulder. The x-ray depicting dislocation was identical to that of the case presented here. Clinically, the arm was held at 45° of abduction. A closed reduction failed. An open reduction was performed at 6½ months of age. Reduction was not possible until the capsule was opened longitudinally and the tendon of the long head of the biceps which was bow-stringing tightly across the head was incised. The result was good. Liebolt and Furey reviewed the literature which failed to reveal previous mention of subcoracoid dislocation in association with brachial plexus palsy. They felt that the condition of obstetrical paralysis and anterior dislocation is probably not as infrequent as suggested by the literature since the combination of paralysis and the abduction external rotation position during treatment provide an excellent combination of etiologic factors. Wickstrom¹¹ has confronted posterior dislocation following treatment of cases of brachial paralysis. He has not had the opportunity to treat a case of anterior subcoracoid dislocation.

Babbitt and Cassidy²³ reported two cases after having reviewed 1,425 with no other record of subcoracoid dislocation. They acknowledged the case of Liebolt and Furey and in all three there was no evidence of dislocation at birth. They believed that the inferior capsule had to be incised in order to gain reduction. This was done in both their cases.



Figure 4a



Figure 4b



Figure 7



Figure 5



Figure 8



Figure 6



Figure 9



Figure 10



Figure 11

Interestingly, one of their cases was not treated in abduction initially. From the date of birth, with negative x-rays, the arm was treated pinned to the chest. At 2½ months there was noted to be an abduction deformity of 90°. Closed reduction failed and an open reduction was performed. As mentioned, these authors determined that the inferior capsule had to be sectioned in order to gain the reduction.

The case presented here is only the fourth to be reported, and if not for Babbitt and Cassidy's one case which developed without abduction positioning, we would infer as did Liebolt and Furey that the combination of paralysis and abduction positioning probably caused the subcoracoid dislocation.



Figure 12



Figure 13



Figure 14

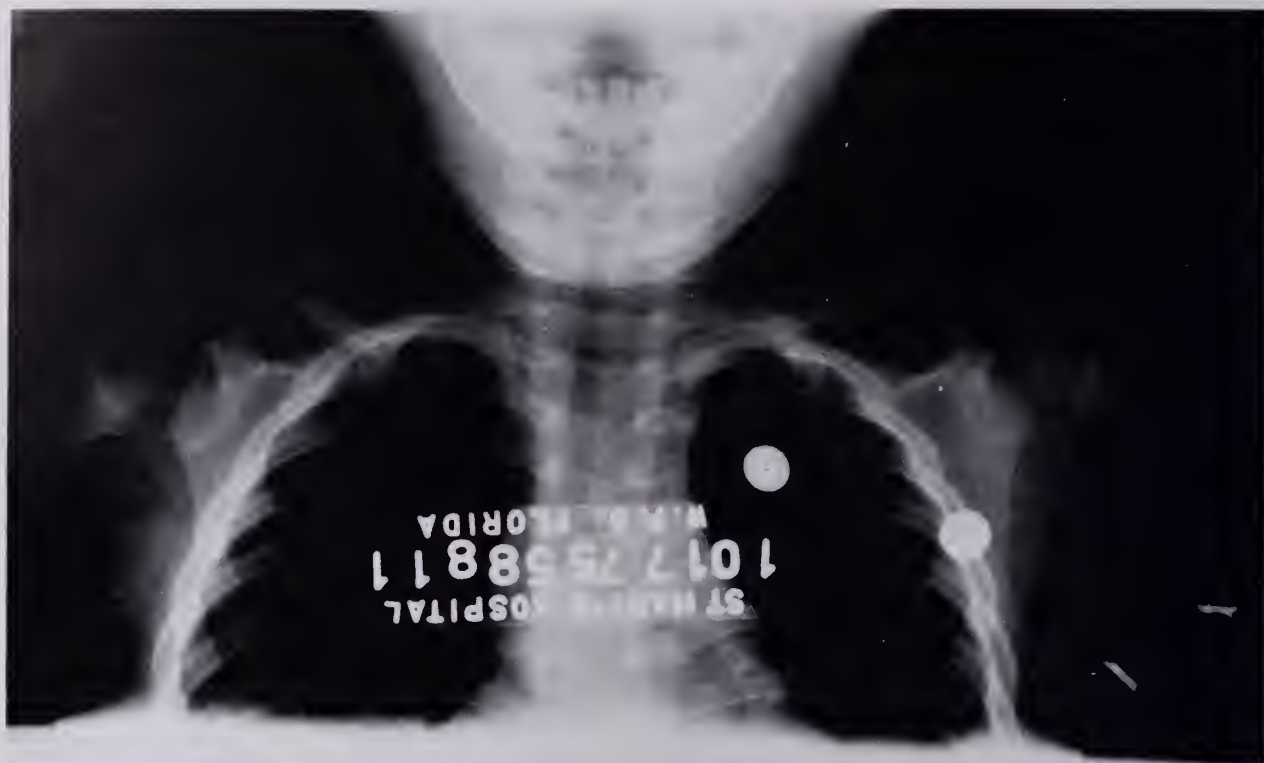


Figure 15

Summary

Birth paralysis continues to occur and we will see one occasionally.

Birth trauma probably does occur but not with the frequency ascribed to it by Scaglietti.

Conservative care should avoid the extreme abduction and external rotation of the airplane position for immobilization. This possibly is the mechanism for producing subcoracoid dislocation.

Surgical reduction for subcoracoid dislocation may encounter thickening of the inferior capsule or bowstringing of the long head of the biceps.

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Does an Intensive Care Burn Unit Really Make a Difference?

Hal G. Bingham, M. D., and Judy Lindquist, R. N.

ABSTRACT: Because of the high costs of maintaining and operating a burn unit, does the unit in fact make a difference in managing a burned patient? A burn unit is useful as a teaching and research center and a high level of expertise can be reached by personnel working in such a unit. Seventy patients which were referred to a temporary burn unit over a two-year period were reviewed. The patients were categorized according to age and percent of body surface area involved. Care in an intensive care burn unit did show improved mortality rates in two categories of patients. In other categories mortality rate remained high. This appeared to be primarily because of respiratory complications and age.

An intensive care burn unit can make a difference. The unit serves as a teaching center where information is disseminated not only to professional personnel but to the general public particularly in fire prevention. The unit cooperates with local, regional, and state firefighting agencies in pointing out to the public that most burns result from preventable accidents that occur in the home and usually involve the extremes of age, i.e., the very young and the very old.¹

The unit can make a difference by research on the pathophysiology of the burn injury which is complex and not completely understood. The Brook Army Burn Unit has been outstanding, particularly over the past several years, in advancing our knowledge in this difficult field.²

An intensive care burn unit is a designated area that brings together a team of specialists who are dedicated to making a difference by improving the management of the patient. Nurses develop expertise in the use of various topical antibiotics by inservice orientation and conferences specifically geared to a better understanding of the burn wound

and the patient.³ Occupational and physical therapists concentrate on improved function for the patient from the day he is admitted until long after he has been discharged and undergone reconstructive surgery. Nutrition experts follow the patient daily and continually make adjustments in his caloric and protein needs which are tremendous. Some experts believe that the patient's defense mechanism and immune system function are directly related to an adequate energy supply. Personnel, then, is the key to the success of a burn unit and a well-trained team consisting of many disciplines can make a difference.⁴

It has been recognized more recently that categorization for severe trauma and specifically burn injury can make a difference and translates into increased survival. The Florida Medical Association sponsored a recent meeting of its Emergency Medical Service Committee and charged the participants with developing categories for severe trauma.* The Committee adopted the American Burn Association's recommendation.⁵

The burn patient can be categorized into a minor, moderate, or major injury by the patient's age, size of wound or percent of body surface area involved. Generally it makes little difference if a minor burn is managed in a community hospital or a burn care facility for this would be an adult patient with less than 15% second degree, with less than 2% third degree, or a child with less than 10% second degree burn.

The moderately burned patient as categorized by the American Burn Association is an adult with less than 25% second degree and less than 10% third degree with no associated complications or a child between 10% and 20% second degree with less than 2% third degree burn. This category of thermal injury certainly requires hospitalization with fluid and burn wound management plus subsequent debridement and skin grafting. While an intensive care burn unit may or may not make a difference for this type patient, personnel should be available who are trained in the care of burned patients and a

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*Emergency Medical Service Committee, Tempe, September 11, 1976.

physician, preferably a surgeon, should be available who is knowledgeable in the field of trauma.

Few practicing physicians can divert enough attention from their private practice to provide the intensive care that is mandatory for the major burned patient. Quite often physicians are glad to relinquish the care of a severely burned patient to a burn unit team. The major burned patient with a body surface area greater than 25% second degree and greater than 10% third degree as well as the pediatric patient with a greater than 20% second degree involvement should be referred to a burn unit where their survival may be significantly different.

Survival can be used as a criterion to determine if an intensive care burn unit really makes a difference.⁶ Our experience with a total of 70 patients who were referred to our temporary burn unit is categorized in Table 1. Age of the patient proved to be as significant in survival as percent of body surface area.

In the age group under 40 years with body surface involvement up to 60%, improved survival was apparent. There were 38 patients in this category and they all survived. Even patients in this age group with between 40% - 60% body surface involvement had a 0 mortality rate. This is an improvement over a 15% mortality rate for that category for non-burn care facilities determined in a recent survey.⁷

Our mortality rate for patients over 40 years with involvement up to 60% was high. Seven patients out of 23 expired but five of the seven had respiratory complications. They required tracheostomies or prolonged intubation with respirators and arterial monitoring and probably could not have been managed as well in a community hospital.

The mortality rate was high for patients with body surface involvement over 60%. Five patients

Table 1. — Relationship of age and percent of body surface burn to mortality.

Age Range	Total Surface Average	Number of Patients	Survival	Mortality
< 40 years	< 60%	38	38	0%
	> 60%	4	3	25%
> 40 years	< 60%	23	16	30%
	> 60%	5	0	100%

over age 40 years expired but three out of four patients survived under the age of 40. Whereas the burn care facility probably did decrease the mortality for patients under 40 years with over a 60% body surface burn, it made no difference for patients over 40 years.

Another criterion for improved burn care is a reduced length of hospital stay.⁸ Table 2 shows that the age of the patient is not as critical as the size of the burn wound in determining the length of hospitalization. In attempting to compare length of stay in the intensive care burn unit with length of stay in a community hospital, it became evident that the critical factors were depth of the wound as well as the body surface involvement.

Table 2 — Age of patient not as critical as size of burn for length of stay in hospital; cost of hospitalization also listed.

Age	Size of Burn	3°	Length of Stay	Cost
40 years	< 40%	5%	24 days	\$ 9,000
	40%-60%	10%	38 days	\$15,000
	> 60%	30%	57 days	\$20,000
40 years	< 40%	9%	27 days	\$11,000
	40%-60%	23%	29 days	\$13,000
	> 60%	70%	8 days	\$ 5,000

(All patients in last category died relatively early post-burn)

Most physicians tend to overestimate the size of the burn wound on initial evaluation. They also have some difficulty in deciding the difference between second and third degree depth. These two points are important in trying to compare patients. If a burn wound initially is overestimated as to percent of body surface involvement and third degree depth, the patient will do much better and get out of the hospital sooner than the patient whose initial estimate is correct.

Length of hospital stay, therefore, could not be used as a criterion for improved care, but our management of the burn wound was aggressive with primary burn wound excision being carried out whenever possible along with primary or early skin grafting. This type of management has resulted in early coverage of the burn wound with decreased scarring and contracture as well as decreased

length of stay. It must be obvious, however, that burn trauma represents catastrophic illness from the standpoint of expense and survival.⁹

We believe that an intensive care burn unit does make a difference in teaching, in research, and in the improved management of the patient.

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"Nth" Psalm (with apologies to King David)

The Hospital Administrator is my shepherd;
though I may not want;

He maketh me a place in his chart room;
he leadeth me there for the sake of JCAH and
Medicare.

He attempts to restore my responsibilities;
for the chart is an instrument of his fiscal
righteousness.
(Medicare won't pay if the chart ain't right)

Yea, though there be a tornado, personal disaster, golf
date or a three week trip to Europe, I have no fear;
for he assures me the charts will still be here.

The Medical Records Department prepares a list of
deficiencies for me in the presence of my colleagues;
even though my current charts runneth over.

Surely, lamentations and exhortations to complete them
shall follow me all the days of my life;
and I shall dwell in the chart room forever.

by
Robert Gowling, Hospital Administrator
and
Norman Vickers, M.D., Physician



ORGANIZATION



Jack A. MaCris, M.D.

They Stood Twice

Never before had a president of the FMA been so acclaimed by a House of Delegates. It happened on January 30, 1977 at the Winter meeting in Lake Buena Vista. Jack A. MaCris received two spontaneous standing ovations in a short period of minutes.

During the meeting, the room was permeated with unanimity as the delegates seemed to experience a new and unique camaraderie. Afterwards, there were no head shaking dissidents, and no clandestine meetings of complainers - only a long queue of physicians waiting to congratulate a superior president.

Long before January 30, many of us already knew this man, and admired and respected him for his abilities, his sincerity, and his unswerving principles. Others began to know him on the day he accepted the gavel and briefly outlined his goals. In presenting the past president's portrait to Mrs. Vernon B. Astler, he noted that "Behind every great man there is a woman - saying "you're wrong, you're wrong, you're wrong." Then, with obvious sincerity, he proceeded to eulogize Vern Astler for a year of great leadership. Before accepting the mantle of the presidency, he proved that old adage - "The bigger the man, the nicer he is" - as he took time to praise his partner, John Orebaugh, calling their relationship "unbelievable - an experience few men enjoy."

Within 24 hours after his elevation to the presidency, Jack was in Tallahassee representing FMA in the battle over professional liability. No President had ever been required to assume so much responsibility so rapidly. He represented us well in the long, tough, demanding fight.

This, however, was only the beginning of both his new responsibilities and his accomplishments. As he continued to work and to lead, there was a significant acceleration in FMA activities.

He provided the karate chop to our PLI problems by his arduous efforts in Tallahassee. The professional manner in which this program was carried out has drawn commendations from legislators in other states, as well as Florida.

The development of the FMA Insurance Reciprocal was a remarkable accomplishment. The extraordinary television prime time Public Relations

program depicted Florida medicine in a most favorable light.

The thrust of Jack's philosophy included recommendations for continued emphasis in Public Relations programs, coordination of legislative activities with county medical societies, active support of FLAMPAC, Emergency Medical Services, and many other programs to improve the health care delivery of our state and to meet the needs of our patients.

He again displayed his courage and wisdom as he worked for the free enterprise system at the AMA Clinical Convention in Philadelphia during our bicentennial year. Withstanding tremendous pressure, he remained firm in opposition to any national health scheme, and so instructed our Florida AMA delegates. His action and determination in that historic city emulated Dr. Joseph Warren and his quarrel with the Tories and George III some 200 years earlier.

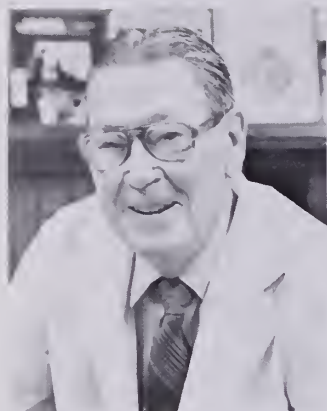
Our President spent endless hours attending committee and board meetings, reading and writing volumes of correspondence, and making public appearances. I've developed the highest respect for his natural ability, and for his willingness to apply it unselfishly in furthering the interests of the FMA. In addition to being a workhorse, Dr. MaCris is an orator, a philosopher, a scholar, and a true gentleman. We, the members of Florida medicine, have benefited greatly from his leadership.

But, that isn't all. Jack MaCris had previously formed a partnership which provided a bonus benefit to the FMA. At his side throughout the presidential year was his wife, Janet, with her personable manner and friendly, contagious smile. Janet possesses charm, charisma and dignity, all of which served us well as she accompanied the President to various official functions. We have been proud to have Janet as our most gracious first lady.

Though Jack's golf scores have suffered during 1976-77, we extend the gratitude of more than 10,960 physicians to two people to whom we are deeply indebted - President Jack and his charming wife, Janet.

Joseph C. Von Thron, M.D.
Cocoa Beach

A. Ashley Weech, M.D. Howland Award Medalist



Dr. Weech

Pediatrics' highest honor was bestowed last month to A. Ashley Weech, M.D., 81-year-old Professor of Pediatrics Emeritus at the University of Florida College of Medicine.

He received the 26th John Howland Award from the American Pediatric Society in San Francisco on April 27th. Awarded

annually since 1952, the Howland Medal and an accompanying grant of \$3,000 are a memorial to John Howland, M.D., longtime chairman of the Johns Hopkins University Pediatric Department who was credited with modernizing pediatrics.

Previous recipients have included Albert B. Sabin, M.D., developer of the oral polio vaccine bearing his name, and a close friend of Dr. Weech.

For Dr. Weech, the Howland award is the latest of many honors he has received. They include the Borden Award from the American Academy

Pediatrics in 1956, and the Abraham Jacobi Award from the American Medical Association Section on Pediatrics in 1967.

Dr. Weech also has the distinction of being the first physician to administer an antibiotic injection in the United States. That was in 1935 when he injected a dose of Protosil, a drug that had been in use for a short time in Germany.

A student of Dr. Howland at Hopkins, Dr. Weech eventually settled in Cincinnati, where he was Professor and Chairman of the Department of Pediatrics at the University of Cincinnati for many years. In 1973, he was appointed Visiting Professor of Pediatrics at the University of Florida, and last year his title was changed to Professor Emeritus.

Last year's medical college graduating class at Florida dedicated its yearbook to Dr. Weech and invited him to present the Commencement Address (see JFMA December, 1976, p.995).

Dr. Weech has served medicine in many high positions. For eight years he was Editor-in-Chief of the **AMA's American Journal of Diseases of Children**. He has also served as President of the Society for Pediatric Research, the American Board of Pediatrics and the American Pediatric Society.

Dr. Richard S. Hodes Elected To House Leadership Team



Dr. Hodes

State Rep. Richard S. Hodes, M.D., of Tampa, has been designated House Speaker Pro Tempore and will assume the post for the 1979 and 1980 sessions of the Legislature.

Dr. Hodes, Treasurer of the Florida Medical Association, will serve under Speaker-designate

J. Hyatt Brown of Daytona Beach. Both men were selected by House Democrats on April 12 in a caucus held much earlier than usual because of a rules change.

Now serving his sixth term in the House, Dr. Hodes has held key posts in that chamber. He formerly chaired the House Committee on Health and Rehabilitative Services and the Committee on Education.

The caucus selected him over Rep. Charles W. Boyd of Hollywood.

EDITORIAL

Amoebic Meningoencephalitis

Primary amoebic meningoencephalitis (PAM) is a relatively new disease entity having first been described in four patients in 1965 by Fowler and Carter in Australia. In 1966, Butt described three cases in Florida, all in the Orlando area and in 1969, he reported a fourth case in Orlando and referred to a fifth which occurred in Fort Lauderdale. Since that time, death of a 23-month-old male in 1971 and a 16-year-old male in 1973 brought the total Florida cases to seven. Considering the millions of people who have been swimming in Florida's freshwater lakes since 1962 when the first case occurred, the public health risk is nominal. Based on lake user data from the Department of Natural Resources, the risk factor is about one case per 2.6 million exposures; however, since the disease strikes young, healthy and active individuals, each death produces extreme anxiety in the populace.

There is a possibility that the actual number of cases may be higher since the symptomatology is that of aseptic meningitis. Retrospective studies in Virginia and Great Britain on preserved specimen, one dating back to 1909, elicited misdiagnosed cases. These errors were of relatively little importance previously since there was no known treatment available. Today, a misdiagnosis would have much greater impact because of the availability of therapy.

Confusion not only has centered around the diagnosis of PAM but around the causative agent as well. Early cases had been attributed to *Acanthamoeba* and *Naegleria*, however, in cases in which amoebae have been isolated from the spinal fluid and/or brain tissues, it is generally agreed that the pathogen is a *Naegleria*. Laboratory studies have shown that *Naegleria gruberi* is not the causative agent because it does not produce death in mice following intranasal instillation, whereas pathogenic *Naegleria* does produce death.

Apparently *Naegleria gruberi* does not excrete the cytolytic enzyme characteristic of pathogenic *Naegleria* which facilitates amoebic invasion of the brain via the cribriform plate. To date, this amoeba has not been officially named and thus, is referred to in the literature as simply pathogenic *Naegleria*, *N. fowleri*, *N. invadens*, and incorrectly, as *N. gruberi*.

Epidemiologically, an exposure to freshwater lakes or streams within five to seven days of the onset of headache is common to all Florida cases with the exception of the 23-month-old child. No exposure site has been identified in this case. The concentration of cases in the Orlando area is curious. Whether this concentration of cases resulted from the acute interest in the disease generated by Dr. C. G. Butt's early work and/or from the distribution of pathogenic *Naegleria* being limited to Orlando lakes was a moot question until recently. Research in progress at the Florida Department of Health and Rehabilitative Services Epidemiology Research Center has ruled out the latter possibility. Of 38 lakes tested in 15 Florida counties, 60.5% (23/38) yielded pathogenic *Naegleria* isolates, 47.4% (18/38) of the lakes have been sampled only once.

Even though this free-living, soil amoeba is probably present in most of our 500 freshwater lakes and possibly freshwater streams as well, epidemiological data indicate that the mere presence of the organism in the water in which thousands of people swim is not a real threat to public health. However, extended bottom swimming, diving, water skiing and "horseplay" facilitate entry of this organism into the nasal passage and under certain conditions, as yet not understood, a fulminating disease develops. The isolation of pathogenic *Naegleria* from the nasal passage of a healthy child following exposure to lake water in Virginia demonstrates that presence of

the organism in the nasal passage does not always result in infection. Host factors apparently play an important role.

Until recently the disease has always been fatal. Amphotericin B has been found to be effective but treatment must be initiated early if survival without sequelae is to be achieved. Because of the wide distribution of pathogenic **Naegleria** in Florida lakes, all physicians in the state must be cognizant of the vital need for early recognition of PAM as a possible diagnosis. During hot summer and fall months when pathogenic **Naegleria** populations in our lakes reach the maximum, all patients seen with high fever, severe, persistent headache alone or, more importantly, accompanied by nausea and vomiting, should be questioned immediately as to exposures to freshwater lakes or streams during the preceding five to seven days. If a positive history is elicited, a spinal tap should be performed. A low sugar, high protein and high cell count in a purulent spinal fluid may be indicative of PAM in the absence of bacteria.

Early in the disease very few trophozoites may be present in the spinal fluid so the maximal quantity of fluid that may be obtained safely should be withdrawn. At this early date a clear spinal fluid may be obtained. After removal of small quantities for cell count, protein, and sugar determinations, the remainder should be concentrated and the sediments used for preparing fresh and hematoxylin stained slide preparations. It may be desirable to warm the fresh slide preparation to encourage amoeboid movements, otherwise amoeba might be mistaken for lymphocytes. Preferably, someone familiar with amoebae should

examine the wet slide preparation. Fluorescent antibody studies and culture of the organism would also be most helpful. Since it requires 24-48 hours for amoeba plaques to develop on inorganic agar plates seeded with bacteria, this latter should be used only as a confirmatory procedure.

If pathogenic **Naegleria** are not seen on the first cerebrospinal fluid exam, but all other indications of PAM are present, intravenous Amphotericin B therapy should seriously be considered, and the spinal tap repeated in 12 to 20 hours. Once amoebae are demonstrated, the addition of intraventricular Amphotericin B therapy is indicated. The rapid course of this disease, five to six days from onset of headache to death, requires early diagnosis and rapid treatment. In spite of the nephrotoxicity and other untoward reactions to the drug, the alternative of death far outweighs these disadvantages. There is always the possibility that a viral encephalitis may be mistaken for PAM, but the reverse is more probably true.

It is hoped that with a better understanding of the disease, its epidemiology and therapy available, fatalities from this disease may be avoided.

There has not been a case of PAM reported in Florida since 1973, but it is merely a matter of time before another occurs. The Epidemiology Research Center in Tampa (813-272-2316) offers laboratory assistance and field epidemiological investigative services to any physician and/or health department in the state when a suspect case of PAM is identified. Hopefully, in the near future the presently held concept that PAM is always fatal may be reversed.

Flora Mae Wellings, Ph.D.
Epidemiology Research Center, Tampa

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Over 80% of the reviews are returned by our colleagues in less than three weeks—a truly remarkable parameter of the intensity of their **Involvement**. Every article is reviewed by at least one physician who has not been invited to participate in our review process previously, so that the JOURNAL may have access to an ever-widening panorama of talent. Many a writer has found his article immeasurably enriched by the reviews that his document has received.

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Particular appreciation must also be expressed to Dr. Jack A. MacCris, our President, Dr. W. Harold Parham, the Executive Vice-President; and to Dr. J. Lee Dockery, Chairman of the Council on Scientific Activities—for their unswerving and effective support of the activities of the JOURNAL.

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ACCREDITED BY THE J. C. A. H.

MEETINGS

Approved by FMA Committee on Continuing Medical Education

JUNE

Florida Suncoast Pediatric Conference, Second Annual Meeting, June 12-15, Sheraton Sand-Key, Clearwater Beach+

Mease Hospital Tumor Board, June 16, Mease Hospital, Dunedin. For information: Paul S. Berger, M.D., 725 Virginia Street, Dunedin 33528.

Twenty Eighth Annual Scientific Assembly, June 22-26, Sandpiper Bay, Port St. Lucie. For information: Florida Academy of Family Physicians, 4057 Carmichael Avenue, Jacksonville 32207.

Post Assembly Seminar, June 26-July 3, Snow Mass, Colorado. For information: Florida Academy of Family Physicians, 4057 Carmichael Avenue, Jacksonville 32207.

JULY

The Problem of Infertility, July 11, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge, M.D., 511 W. Highland Blvd., Inverness 32650.

SEPTEMBER

Tips, Tricks, Traps and Techniques, Sept. 9-11, Sea Turtle Inn, Jacksonville Beach. For information: Duke H. Scott, M.D., 1205 Beach Boulevard, Jacksonville Beach 32250.

Colon and Rectum Cancer Conference, Sept. 10, Tampa.+

The Problem of Microscopic Hematuria, Sept. 12, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge, M.D., 511 W. Highland Blvd., Inverness 32650.

OCTOBER

Immunologic and Pharmacologic Advances in Diagnosis and Treatment of Allergic Illness, Oct. 21, Tampa.+

Scientific Assembly of Interstate Postgraduate Medical Association of North America, Oct. 31 - Nov. 3, Diplomat Hotel, Hollywood. For information: Alton Achsner, M.D., Post Office Box 1109, Madison, Wisconsin 53701.

NOVEMBER

The Problem of Glaucoma, Nov. 14, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge, M.D., 511 W. Highland Blvd., Inverness 32650.

*For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152, Tel. (305) 547-6716.

**For Information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143.

+For Information: Contact Theron A. Ebel, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2074.

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SPECIALISTS

INTERNIST, UROLOGIST, GP's.: Outstanding opportunities in progressive nonurban community serving 20,000. Write John H. Parker, M.D., Chief of Staff, Doctors Memorial Hospital, Perry, Florida 32347.

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ORTHOPEDIC SURGEON, DERMATOLOGIST. Immediate openings. Private solo practices. Liberal financial assistance including guaranteed income and free rent for first year. Attractive community, good schools. Contact Claude L. Weeks, Ex. Dir., Flagler Hospital, P.O. Box 100, St. Augustine, Florida 32804. Phone: (904) 824-8411.

WELL-ESTABLISHED SOLO INTERNIST with fully equipped 2,100 square foot, two-man office with x-ray, lab, all facilities, desires internist or other suitable physician for office sharing arrangement. Would consider cross-coverage. Write C-792, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST WITH SPECIAL INTEREST IN NONINVASIVE CARDIOLOGY. Immediate opening. Private solo practice. Financial assistance including first year free rent. Attractive community, good schools. Contact Claude L. Weeks, Executive Director, Flagler Hospital, P.O. Box 100, St. Augustine, Florida 32084. Phone: (904) 824-8411.

INTERNIST WANTED: For association with five internists. Southeast coast of Florida. Under age 35, board qualified, Florida boards not necessary. Annual salary \$35,000. Early partnership assured. Write C-797, P.O. Box 2411, Jacksonville, Florida 32203.

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CONFERENCES FOR MEDICAL PROFESSIONALS. A calendar listing of over 500 national/international meetings, conferences and seminars in the medical sciences for 1977. All medical specialties included. Send a \$10.00 check or money order payable to Professional Calendars, P.O. Box 40083, Washington D. C. 20016.

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FAMILY PRACTITIONER OR INTERNIST wanted to share facilities with five practitioners in solo practice. Major equipment provided. Rent \$250.00 per month. Excellent laboratory and x-ray with income based on use. Bookkeeping system shared. Financial assistance available to the right party. Contact T. C. Kenaston Jr., M.D., Box 550, Cocoa, Florida 32922.

ASPEN MUSHROOM CONFERENCE. Diagnosis and treatment of mushroom poisoning. Collection. Identification. Microscopy. Novice and advanced courses. AMA Category I. August 7-12. Hotel Jerome, Aspen, Colorado. Contact: Beth Israel Hospital, 1601 Lowell Blvd., Denver, CO 80204. (303) 825-2190. Ext. 354.

WANTED: Physician to join several other physicians in emergency room practice in central Florida community hospital, 150 beds. Forty hour week. Benefits include 3 weeks vacation and 2 paid medical conferences. Starting salary \$40,000 yearly. Must be graduate of U.S. medical school, have AMA internship, and some previous practice desirable. Florida license necessary. Contact: James N. Kulpan, Administrator, Waterman Memorial Hospital, P.O. Drawer B, Eustis, Florida 32726. Phone: (904) 357-4161.

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WANTED—ANY M.D. FROM JUNE 1 TO AUGUST 18, 1977, to do form examinations for insurance, employment, school, etc. 20 hour week, no calls. Salary \$400/week, home available. Sarasota, Florida. Call collect Dr. Troyer, (813) 922-2334 or (813) 959-6507.

Situations Wanted

CARDIOLOGIST—FLORIDA LICENSED — desires hospital based, group or solo practice. University trained in clinical cardiology, noninvasive techniques (echocardiography—right heart catheterization). Currently director of CCU. Available July 1977. Write C-775, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST, 32, certified in pulmonary medicine wishes to relocate. Experienced in academic hospital based patient care, licensed in Florida. Prefers West coast; will consider offers from hospitals, groups or quality internists for association. Write C-781, P.O. Box 2411, Jacksonville, Florida 32203.

30 YEAR OLD MALE GENERAL SURGEON, good experience peripheral vascular surgery available July 1977. Partnership, group or solo practice. Contact D. Mobed, M.D., 80 Guion Place, New Rochelle, New York 10801.

CARDIOTHORACIC SURGEON, University trained, open heart, coronary bypass and valvular surgery. Florida licensed. Seeks position with established group. Write C-785, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST-SUBSPECIALTY ALLERGY, board certified in both, Florida license, American graduate, ten years practice experience, desires group or solo practice. Write C-767, P.O. Box 2411, Jacksonville, Florida 32203.

ANESTHESIOLOGIST available from August '77. Board eligible on July 31, 1977. Possessing a Florida license. Over five years experience in anesthesiology. Experience in England also. Write C-783, P.O. Box 2411, Jacksonville, Florida 32203.

PATHOLOGIST, 32, wife pediatrician, both university trained, FLEX licensed in Illinois and board qualified, desire suitable placement in Florida. Available July 1977. Contact Dr. Bala, 526 Maple Lane, Darien, Illinois 60559. Phone: (312) 963-2133.

CARDIOLOGIST, BOARD CERTIFIED, 35, experienced in clinical cardiology and noninvasive techniques. Seeks association, group or hospital practice. Knowledge Spanish. Write C-793, P.O. Box 2411, Jacksonville, Florida 32203.

ORTHOPEDIC SURGEON, 30, married, university trained, available July 1978. Experienced in total joint replacement, desires partnership, group, or solo on Florida coast. American, Bilingual, Spanish-English. Write C-794, P.O. Box 2411, Jacksonville, Florida 32203.

32 YEAR OLD 3RD YEAR INTERNAL MEDICINE RESIDENT at Mayo Clinic available for locum tenens or E. R. work any part of July - mid September '77. Write C-795, P.O. Box 2411, Jacksonville, Florida 32203.

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OB-GYN — 49 years old, boarded, A.C.O.G., A.C.O.S., experience in laparoscopy, culdoscopy, family planning, etc. Wishes to relocate as solo or with group. Available this summer. Write C-798, P.O. Box 2411, Jacksonville, Florida 32203.

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PULMONARY INTERNIST, 29, A.B.I.M., F.M.G., seeks solo or part time hospital-based practice. Available July 1977. Well trained pulmonary functions, intensive care, respiratory therapy. Write C-800, P.O. Box 2411, Jacksonville, Florida 32203.

38 YEAR OLD BOARD CERTIFIED INTERNIST with gastroenterology subspecialty; full endoscopy training, seeks to relocate to Florida summer 1977 as soloist or with group/partnership. Write C-801, P.O. Box 2411, Jacksonville, Florida 32203.

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PA IN ANESTHESIOLOGY/LIFE SUPPORT SYSTEMS seeks practice with group or University; highly trained in anesthetic management, life support technology and critical care. For resume, write: Michael Gilliland, 1170 Briarcliff Court #6, Atlanta, Georgia 30306.

BOARD CERTIFIED INTERNIST, 36, with interests in continuing medical education programming and diving medicine seeks association or group practice in Internal Medicine in coastal southern Florida. Willing to consider institutional post. Has developed and directed programs in rural health care organization and continuing education in conjunction with the University of Minnesota. Plan to be available mid September 1977. For further information and CV write to Dr. Stephen L. Zuckerman, Medical Director, Northwest Hennipin Project, Box 32, University of Minnesota Hospital, Minneapolis, Minnesota.

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PHYSICIAN RETIRING: TAKE OVER PRACTICE in July 1977, fast growing area of S. W. Florida. Three hospitals in area. Write C-790, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNAL MEDICAL PRACTICE in North Miami, Florida, available for sale. Write C-746. P.O. Box 2411, Jacksonville, Florida 32203.

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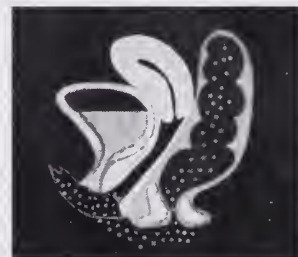
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Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days



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- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
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Before prescribing, please consult complete product information, a summary of which follows:

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Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. **CNS reactions:** Headache,

peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarthritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

***Pneumocystis carinii* pneumonitis:** Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).



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Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introital colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

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101st President of the Florida Medical Association

**Florida Legislature Reenacts Professional
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A character all its own.



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Pharmacologically, it has been described as more potent mg-per-mg than other available anxiolytic benzodiazepines. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

Valium[®] (diazepam)^{IV}

2-mg, 5-mg, 10-mg scored tablets
**a prudent choice in psychic
tension and anxiety**

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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June 1, 1977

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JUNE COVER — Louis C. Murray, M.D., of Orlando, 101st President of the Florida Medical Association.

consider the effect on coexisting diabetes when you prescribe a vasodilator*



(POSTERIOR VIEW OF PANCREAS)

no interference in the management of the diabetic patient has been reported with

VASODILAN® (ISOXSUPRINE HCl) the compatible vasodilator

TABLETS, 20 mg.

***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.
Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.

Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

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Brief Summary

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(ERYTHROMYCIN ETHYLSUCCINATE TABLETS, ABBOTT)

Indications:

Streptococcus pyogenes (Group A beta hemolytic streptococcus)—Upper and lower respiratory tract infections, skin, and soft tissue infections of mild to moderate severity, where oral medication is preferred. Therapy should be continued for 10 days.

Alpha-hemolytic streptococci (viridans group)—Short-term prophylaxis of bacterial endocarditis prior to dental or other operative procedures in patients with a history of rheumatic fever or congenital heart disease who are hypersensitive to penicillin.

S. aureus—Acute infections of skin and soft tissue of mild to moderate severity. Resistant organisms may emerge during treatment.

S. pneumoniae (*D. pneumoniae*)—Upper and lower respiratory tract infections of mild to moderate degree.

M. pneumoniae—For respiratory infections due to this organism.

Hemophilus influenzae: For upper respiratory tract infections of mild to moderate severity when used concomitantly with adequate doses of sulfonamides. Not all strains of this organism are susceptible at the erythromycin concentrations ordinarily achieved (see appropriate sulfonamide labeling for prescribing information).

Treponema pallidum—As an alternate treatment in patients allergic to penicillin.

C. diphtheriae and *C. minutissimum*—As an adjunct to antitoxin. In the treatment of erythrasma.

Entamoeba histolytica—In the treatment of intestinal amebiasis.

L. monocytogenes—Infections due to this organism.

Establish susceptibility of pathogens to erythromycin, particularly when *S. aureus* is isolated.

Contraindications:

Known hypersensitivity to erythromycin.

Warnings:

Safety for use in pregnancy has not been established.

Precautions:

Exercise caution in administering to patients with impaired hepatic function. During prolonged or repeated therapy, there is a possibility of overgrowth of non-susceptible bacteria and fungi. Surgical procedures should be performed when indicated.

Adverse Reactions:

Dose-related abdominal cramping and discomfort. Nausea, vomiting, and diarrhea infrequently occur. Mild allergic reactions such as urticaria and other skin rashes may occur. Serious allergic reactions, including anaphylaxis, have been reported.

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of its kind**
when erythromycin therapy
is indicated



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**May be taken before,
after or with meals**

Helps insure reliable blood levels
regardless of when dosage is taken.

Rapid, consistent blood levels occur under
either fasting or nonfasting conditions.

Allows you to tailor dosage instructions
to patient's needs or lifestyle.

Helps combat day-to-day lapses
in dosage compliance.

Important for patients who can better
remember to take their dosage at
mealtime rather than "between
meals."



Consider E.E.S. 400 Filmtab[®]. In a class by itself.

Please see opposite page for Brief Summary.



Dean's Page

Quality Education

William B. Deal, M.D.

The University of Florida College of Medicine on May 28, 1977 awarded 111 women and men the Doctor of Medicine degree. They joined nearly 1,000 graduates of the College since the first class graduated in 1960. This, the largest graduating class, entered medical school in 1973 at the peak of enrollment expansion experienced nationwide. In five short years, this expansion has increased the undergraduate enrollment at the College of Medicine by 81%.

Costs of medical education have unfortunately escalated in parallel to this expansion with the current annual cost of approximately \$12,000 per M.D. student per year. (Graduate programs in the basic sciences, graduate medical education and non-degree technician training cost are not included in the above figure). Medical education is expensive because of the requisite teaching facilities, and a low student-faculty ratio required for clinical teaching.

Who pays these costs? The Federal Government through capitation, research grants and training grants contribute 24%; the VA Hospital and Teaching Hospital together contribute 17% professional fee income, 20%; indirect cost, 11%; and state appropriations, 28% (including tuition). In the last five years, there has been a definite trend of decreasing federal and state support with a dramatic increase in the contribution made by the medical faculty.

Florida too has experienced population and economic growth in the past with nearly 4,000 new residents per week. The growth has resulted from an unsurpassed climate, job opportunities, and a favorable taxation climate. Other attracting features include a vast expanse of beaches, numerous lakes, and good roads which serve our large tourism

industry and allow us, the citizens, to enjoy this great State. Therefore, several questions must be answered. With increasing inflation and diminishing fossil fuel supply, will our growth continue? Will tourism remain a major industry with the limited fuel supply? Since our tax base is predominantly based on retail sales, will decreased tourism bring a chronic recession such as experienced in 1974? With less than the best in education, how can we assure Floridians, present and future, that their children will not ultimately leave the State for superior educational and employment opportunities?

There are two interconnected solutions: (1) Broaden the tax base to insure more stability in public funding and (2) Vigorously recruit clean industry to Florida. Most would surely agree that for the eighth most populous (and not the poorest) State in the union something is amiss when we are 48th of 50 nationally in supporting higher education. However, without quality education at all levels, it will be difficult, if not impossible to attract the type of industry that will be required to maintain our State.

Higher education in the State of Florida is an asset beneficial to every Floridian: young and old, working and retired, healthy and sick. The future of our State, socially and economically, is dependent on the quality of the higher educational systems.

Floridians deserve and should demand the best in education. Because of decreasing dollars available for education, the last two years have been difficult for institutions of higher learning to maintain quality. It is time for us to re-examine our priorities.

Quality higher education in Florida may not survive another recession!

Dr. Deal, Acting Dean of the University of Florida College of Medicine, writes this month's Dean's Page in place of Dean Chandler A. Stetson, M.D., who died last month.

• Dr. Deal, University of Florida College of Medicine, Gainesville 32610.

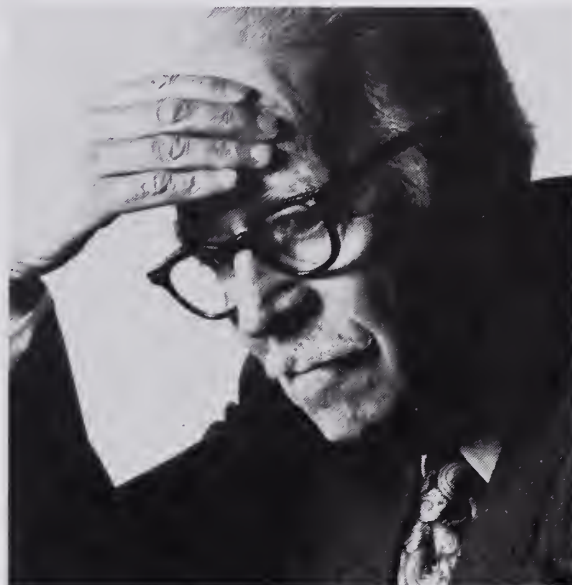
A TOTALLY NEW DELIVERY SYSTEM TO HELP REDUCE THE FEAR OF ANGINAL ATTACKS

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Controlled sustained release of ISO-BID's isosorbide dinitrate through micro-dialysis diffusion can help reduce frequency and intensity of anginal attacks. This in turn can minimize patient's fear of attacks, and dependence on nitroglycerin.

Unlike ordinary sustained release products, ISO-BID releases isosorbide dinitrate at a smooth, continuous, predictable, controlled rate to provide for up to 12 hours of therapeutic activity. Micro-dialysis is dependent only upon the presence of fluid in the G.I. tract and not on pH or other variables. ISO-BID is particularly advantageous in the prevention of nocturnal angina.

DOSAGE: One ISO-BID capsule every 12 hours on an empty stomach according to need, for continuous 24-hour therapy. Some patients may require higher dosage levels. In these patients, dosage should be titrated, and they may require two ISO-BID capsules b.i.d. Not intended for sublingual use. Consult product brochure before prescribing.

THERAPEUTIC FOOTNOTE: IN TREATING ANGINA . . . FAILURES MAY RESULT FROM INADEQUATE DOSAGE. Reports in the literature indicate the usefulness of higher dosage levels of isosorbide dinitrate.^{1,2}

INDICATIONS: Based on a review of this drug by the National Academy of Sciences — National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: For the relief of angina pectoris (pain of coronary artery disease). ISO-BID is not intended to abort the acute anginal episode, but is widely regarded as useful in the prophylactic treatment of angina pectoris. Final classification of the less-than-effective indication requires further investigation.

CONTRAINDICATION: Idiosyncrasy to this drug.

WARNINGS: Data supporting the use of nitrites during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety.

PRECAUTIONS: Use with caution in patients with glaucoma. Tolerance to this drug, and cross-tolerance to other nitrates and nitrites may occur.

ADVERSE REACTIONS: Cutaneous vasodilation with flushing. Headache may commonly occur, and may be both severe and persistent. Transient dizziness

and weakness, in addition to other signs of cerebral ischemia associated with postural hypotension may occasionally be seen. ISO-BID can act as a physiological antagonist to norepinephrine, histamine, acetylcholine and many other medications. An occasional patient may show marked sensitivity to the hypotensive effects of nitrite; severe responses (nausea, vomiting, weakness, restlessness, pallor, excessive sweating and collapse) can occur, even with the usual therapeutic dosage; alcohol may enhance this effect. A drug rash and/or exfoliative dermatitis is occasionally seen.

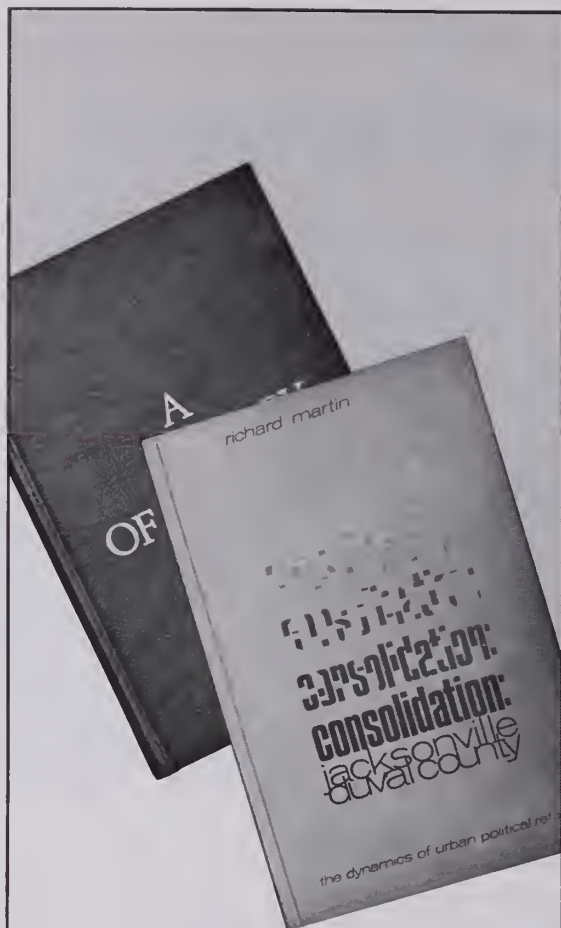
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ANTIMINTH® (pyrantel pamoate) **ORAL SUSPENSION**

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 $\mu\text{g/ml}$) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

More detailed professional information available on request.

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Antiminth[®]
(pyrantel pamoate)

equivalent to 50 mg pyrantel/ml
ORAL SUSPENSION



a drug of choice in
pinworm infections

Please see brief summary of prescribing information on facing page.

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RECENT CHANGES

federal register

**Providing
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to Physicians**

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special report
**Malpractice
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**drug
bulletin**

**Health care doesn't
need more red tape**

**Drug firms challenge
'MAC' rules**

**Drug
Substitution**

**The Consumer Representative
of Health Progress
RESEARCH**

Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

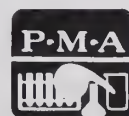
generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005



FROM THE EDITOR'S DESK

BURY THE HATCHET

Two top AMA officials have called for doctors and lawyers to settle their differences. President Richard E. Palmer, M.D., speaking at a symposium sponsored by the AMA and the American Bar Association, warned: "There is a danger that in the heat and strife of the moment, we may allow a permanent rift to develop between our two professions." President-elect John H. Budd, M.D., attributed current differences between the professions to attempts by both camps to do their best for patient and plaintiff.

* * * *

SENIOR CITIZEN PHYSICIANS

Retired physicians will be getting a 50% discount in course fees charged at AMA Annual Conventions and regional meetings. Meanwhile, the American Retired Physicians Association has begun a membership recruitment campaign with the mailing of a brochure, "How Can You Get More Out of Your Retirement?"

* * * *

COST CONTAINMENT

The Carter Administration has asked Congress to approve a permanent hospital cost containment program. The Administration's revised budget sets a limit of about 9 per cent in increases in reimbursement for operating costs per admission for each hospital for the year beginning October 1. Other features of the system include separate controls on hospital outpatient departments to encourage alternatives to inpatient care; and programs to encourage other cost containment activities such as second opinion before surgery; pre-admission review for non-emergency hospital care.

* * * *

SUCCESSFUL COUNTERSUITS

Two physicians who retaliated at malpractice suits have won countersuits. Charles F. McCuskey Jr., M.D., of Reno, Nev., was awarded \$85,000 from an attorney who filed a suit against him in 1974. This is said to be the largest sum ever awarded a physician in a countersuit. The other physician, Henry G. Edwards, M.D., of Terre Haute, Ind., settled for \$100 in damages and court costs in his countersuit against a plaintiff.

* * * *

PSRO REGULATIONS

The AMA has complained that HEW regulations proposed for Professional Standards Review Organizations (PSROs) are unjustifiably detailed and restrictive. The rules concern procedures for designation of conditional PSROs, for exercising review authority, and for delegation of review authority to hospital utilization review committees. One HEW proposal would subject PSROs to monitoring by Medicare intermediaries and state Medicaid agencies.

* * * *

INFANT MORTALITY DECLINES

The United States' infant mortality rate was the lowest on record last year. According to the National Center for Health Statistics, there were 15.1 deaths per 1,000 live births, down from the 16.1 recorded for 1975.

The Editor

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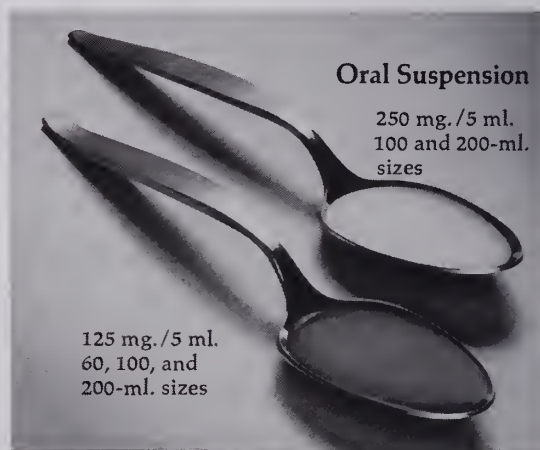
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Retinal Spontaneous Venous Pulsations In Neurologically Ill Patients Incidence and Significance

John C. LoZito, M.D.

ABSTRACT: The incidence of spontaneously occurring retinal venous pulsations was determined under "field conditions" in 420 consecutive neurological consultations. In contrast to the high incidence (90%) found in normal populations, only 40% of this group had spontaneous venous pulsations (SVP). This incidence was related to age, disease process, and intracranial pressure. SVP were seen to decrease in incidence with age and vascular disease. No patient with an intracranial neoplasm or with intracranial hypertension had SVP. It was found that SVP are a reliable sign, when present, of normal intracranial pressure. Their absence is a sensitive, but not specific, early sign of increased intracranial pressure.

Loss of spontaneous pulsations in the retinal veins is one of the earliest signs of papilledema secondary to increased intracranial pressure.¹ Despite the importance of this sign, its incidence and significance among neurologically ill patients is unknown. This study was conducted to determine the incidence of spontaneous venous pulsations (SVP) in such a group with particular emphasis upon the age and clinical status of the patients.

Method

The population consisted of 420 patients consecutively examined in the emergency rooms and wards of two general hospitals. SVP were sought in one or both eyes using a standard direct ophthalmoscope through undilated pupils. The patients suffered from a representative variety of

acute neurologic diseases, were of various ages, and from different socioeconomic backgrounds. Most were acutely ill and supine. Patients who had lumbar punctures prior to the ocular examination were excluded to avoid this complicating factor which might have affected the incidence of SVP. Neither blood pressure nor intraocular pressure were measured.

Results

Twenty patients were either uncooperative or had eye disease sufficient to prevent adequate visualization of the fundi. They were eliminated from statistical analysis. The diagnostic breakdown of the remaining 400 patients was: cerebrovascular disease 94, seizure disorders 55, unconsciousness secondary to metabolic disturbances 32, head trauma 50, cerebral neoplasm 17, functional disorders 22, peripheral neuropathies 36, central nervous system infections 15, headache evaluations 19, syncope evaluations 13, undiagnosed disease 11, and the remaining 36 comprised a miscellaneous group of organic disorders with no single category exceeding six patients.

The overall incidence of SVP in the 400 neurologically ill patients was 40% and the incidence in the first and last 50 patients examined was 34% and 36% respectively. The incidence of SVP decreased with increasing age. (Fig. 1). Less than 20% of persons over age 70 had SVP, whereas greater than 50% of persons under 40 had SVP. (Table 1).

Sixty-five patients underwent lumbar punctures in the lateral recumbent position within

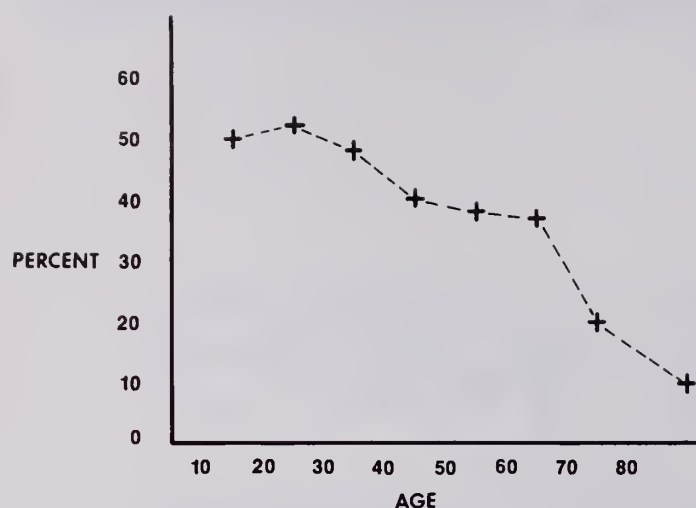


Fig. 1. — Plot of percentage of patients with SVP in various age groups. The incidence decreased with advancing age.

Table 1. — The Relationship of Age to SVP.

Age Groups	Number Patients	Number & Percent With SVP
10-19	18	9 (50%)
20-29	56	30 (53.5%)
30-39	35	17 (48.5%)
40-49	64	26 (40.5%)
50-59	101	38 (38%)
60-69	83	31 (37%)
70-79	34	7 (21%)
80-up	9	1 (11%)

30 minutes after ophthalmic examination for SVP. (Table 2). Nineteen patients had opening pressures greater than 200 mm of water and none had SVP. Nine of these patients had recognizable papilledema. One patient with an opening pressure recorded at exactly 200 mm of water had SVP. Of the 45 other patients with pressures of 195 mm or less, 21 had SVP for an incidence of 46% which approximates that of the total patient population.

None of the 17 patients with cerebral neoplasms had SVP. One patient with a cerebellar metastatic lesion had early disc swelling and SVP

when initially examined, but several hours later SVP were no longer present and never returned. No other patient with papilledema or neoplasm had SVP.

Patients with head trauma had a 16% and those with cerebrovascular disease a 25% incidence of SVP. The low values in both these groups possibly related to cerebral swelling. The patients with seizure disorders had a variety of causative etiologies and an overall incidence of 41.5%. Only three of the 32 patients in metabolic coma had SVP, whereas only one patient with functional disease failed to demonstrate SVP. Fifty five percent of the peripheral neuropathy group, 73% of the headache group, and 46% of the syncope group had SVP. Only two of the 15 patients with central nervous system infectious diseases had SVP.

Discussion

The mechanism responsible for spontaneous pulsations of the retinal veins relates to a balance of the intraocular tension and intracranial venous pressure.²⁻⁵ Choroidal arterial filling during systole slightly raises the intraocular pressure thereby compressing the veins. During diastole the venous pressure again exceeds the intraocular tension and the vein expands. Increased intraocular pressure from glaucoma or by slight extraglobular finger compression may cause venous pulsations which were otherwise absent. Increased intracranial pressure may be transmitted via the venous system or the subarachnoid space surrounding the optic nerve to the retinal veins, thus resulting in the loss of spontaneous venous pulsations.

SVP were found only on the disc and best visualized as the vessel turned downward into the physiologic cup. Three types of SVP were noted. The most frequent and easiest to visualize was a longitudinal, to-and-fro pulsation of the end of the

Table 2. — Relationship of CSF Pressure and SVP.

mm of Water	Number Patients	Number With SVP
250-up	11	0
200-249	8	1
175-199	5	3
150-174	17	5
125-149	11	5
100-124	13	8

vein as it dipped downward. The other types were less common and consisted of either a transverse expansion of the vein or a pulsating change in the color of the vein. Motion of the examiner or patient or the patient's small saccadic eye movements may create the illusion of pulsations because of the parallax between the arteries and veins, resulting in the falsely positive finding of SVP.

The incidence of SVP has been previously reported by ophthalmologists in normal populations as approximately 60-90% with no decremental relationship to age ever mentioned.^{2,8} The presence of SVP in normal patients generally requires a lumbar spinal fluid pressure of less than 200 mm of water.^{7,8} However, only 40% of our 400 neurologically ill patients had SVP. Furthermore, only 46% of the 45 patients with documented CSF pressures of 195 mm of water or less had SVP. This study clearly demonstrates that factors other than increased intracranial pressure results in loss of SVP. One such factor appears to be advancing age but others, presumably related to acute neurologic disease, are more difficult to define.

The incidence of SVP would obviously be higher if observed in a controlled, dimly-lighted environment, with dilated pupils through a Hruby lens. This study, however, was intended to

determine the usefulness of SVP as a sign of increased intracranial pressure in the same clinical setting in which its presence or absence dictates critical decisions about patient management. The absence of SVP is a sensitive, but not specific, indicator of cerebral neoplasm and increased intracranial pressure. Patients with normal spinal fluid pressures but of advanced age or with vascular disease may not have observable SVP. When present, however, SVP are a reliable sign of normal intracranial pressure.

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More Training for Staff Emphasized

Mentally retarded persons in Florida should benefit from a staff development and training program announced by the Retardation Program Office of the Department of Health and Rehabilitative Services in Tallahassee. There are approximately 5,600 persons who provide direct care to the mentally retarded or have other duties involving their welfare.

The program is a combination of institutes and satellite centers specializing in a variety of activities. Institutes are to be located at the Miami and Gainesville Sunland Centers and satellite centers at Sunland Centers in Marianna, Tallahassee, Orlando, and Ft. Myers. In addition, training specialists will be assigned to Jacksonville and St. Petersburg.

Responsibility of the institutes staffed by trainers and instructional design specialists includes identification of problems which require additional training as a part of their solution,

development of alternative approaches to staff training needs, and development of materials and procedures for carrying out training, conducting workshops, and seminars.

The satellite centers will implement training programs produced by the institutes and also assist in the design and development process. The Retardation Program's Office Training and Research in Tallahassee is responsible for providing direction, quality control, consultation and technical assistance.

A unique facet of the training program is the Practicum Observation and Demonstration Site concept which is a carefully supervised training environment for new employees entering the service delivery system. Four Sunland Centers have units and also provide staff members to assist in training new employees as they work with patients. More than 100 hours of training will be provided before they are assigned to a duty station.

Juvenile Rheumatoid Arthritis At University of Florida Six-Year Experience

Jack H. Hutto Jr., M.D., and Ella M. Ayoub, M.D.

ABSTRACT: The clinical and laboratory findings on 145 children with Juvenile Rheumatoid Arthritis treated over the past six years in our Clinic are presented. Prevalence of this disease in white and black children was proportional to their representation in the general population of this geographic area. Systemic presentation was the most common subtype encountered. Iridocyclitis commonly associated with pauciarticular JRA, was seen in only four of our patients, three of whom presented with polyarticular disease. An abnormal erythrocyte sedimentation rate was the most common abnormal laboratory finding, while the latex-agglutination test for rheumatoid factor was positive in only 10% of our patients. Thrombocytosis was frequently present during the acute disease. Salicylate therapy was the most effective form of therapy when used properly.

Juvenile rheumatoid arthritis (JRA) is a common chronic disease of unknown cause predominantly but not exclusively affecting children. While the major symptoms and changes are mediated by the inflammatory processes and appear in articular and related structures, any organ system may be involved. Over the past six years, 190 children seen in our Infectious Disease, Immunology and Rheumatology Clinic were suspected of having JRA. The relatively high prevalence of this disorder in our patient population prompted us to survey our experience with this disease and to compare our findings with those reported from other medical centers in the United States.¹⁻⁵

Dr. Hutto is a research fellow of the Suncoast Heart Association.
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Distribution and Incidence

The geographic distribution of JRA is still not well delineated. Some studies indicate that the highest incidence is between latitudes of 50 and 60 degrees north.¹ Based on recent surveys⁶ which suggest that approximately 250,000 children are affected by the disease in this country, it is estimated that 10,000 children suffer from the disorder in Florida. The racial distribution in our patients parallels that of the general population (Table 1). This finding contrasts with studies from other areas which describe a lower frequency in black children.⁴

Problems of Classification and Diagnosis

Although the disease was recognized earlier,⁷ the first clear description of the heterogeneity of the manifestations of JRA is found in the report by George Still in 1897.⁸ As early as 1891, Diamantberger pointed out the good prognosis peculiar to this disease in children.⁹

**Table 1. — Patients With Juvenile Rheumatoid Arthritis
University of Florida 1969-1976.**

Onset	Number	Sex		Race	
		Male	Female	White	Black
Polyarthritis	44 (31%)	14 (22%)	30 (34%)	35 (29%)	9 (38%)
Pauciarticular disease	28 (20%)	15 (22%)	14 (16%)	26 (21%)	3 (13%)
Systemic disease	72 (50%)	37 (57%)	35 (39%)	60 (50%)	12 (50%)
Total patients	145	66 (45%)	79 (55%)	121 (83%)	24 (17%)

Definitive criteria for diagnosis of JRA such as, for example, the modified Jones Criteria¹⁰ for the diagnosis of acute rheumatic fever, do not exist. The difficulty with development of good criteria for diagnosis of JRA arises from the varied and nonspecific clinical features of patients. However, helpful guidelines have been established by the American Rheumatism Association¹¹ (Table 2). Of the 190 patients referred to us from Florida, Georgia and Alabama, 145 met these criteria. The excluded 45 patients included 14 with final diagnoses of rheumatic fever, five with systemic lupus, six with pyogenic arthritis or osteomyelitis, two with inflammatory bowel disease, and two with leukemia. The remainder fell in a variety of diagnostic categories.

Current criteria for identification of subtypes of JRA in this country are based on clinical findings presenting in the first six months of disease.^{3,5} These subtypes include: the systemic onset which

features multiple organ system involvement sometimes without arthritis, polyarthritis which involves more than four joints with synovitis, and oligoarthritis or pauciarticular rheumatoid disease with arthritis limited to less than five joints.

Clinical Features

The distribution of the subtypes encountered in our patients is outlined in Table 1. Systemic JRA, the most common presentation, was characterized by prolonged or recurrent high, spiking fever, usually without toxicity, characteristic salmon-pink evanescent rash and reticuloendothelial hyperplasia. Several patients additionally developed pericarditis and/or pleuritis, features which are rare but impressive when present. One patient presented in coma with central and peripheral neuropathy secondary to a presumed vasculitis. In patients presenting with arthritis, polyarthritis was the most common form, occurring in 31% of our patients. This clinical feature, as has been previously described, predominated in females.¹⁻⁵ Pauciarticular rheumatoid disease is distinguished from the other modes of onset in that the natural history is more indolent. Slit-lamp examination was performed initially on all patients and repeated at 6-12 month intervals. Although reports from other centers have emphasized the frequent association of this complication with pauciarticular JRA, our examination revealed chronic iridocyclitis only in three patients all of whom presented with polyarticular disease. The only patient with acute iridocyclitis had pauciarticular disease. The serums of these patients were tested for anti-deoxyribonucleoprotein (anti-DNP) and none were found positive. Testing for other nuclear antibodies was not performed. Arthritis predominated in the large joints in all subtypes. The hallmark of involvement in all three subtypes appeared to be development of stiffness following periods of relative inactivity.

Table 2. — Criteria for Diagnosis of Juvenile Rheumatoid Arthritis.

1. Arthritis of 3 months manifest by
 - A. Swollen joint or
 - B. Two of the following
 1. Pain or tenderness
 2. Heat surrounding the joint
 3. Limitation of joint mobility
2. Arthritis of 6 weeks and including one of the following additionally

A. Characteristic rash	E. Pericarditis
B. Presence of rheumatoid factor	F. Tenosynovitis
C. Development of iridocyclitis	G. Intermittent fever
D. Cervical spine involvement	H. Morning stiffness
3. Exclusion of all diseases in the following categories must be accomplished

A. Rheumatic fever	G. Inflammatory bowel disease
B. Collagen-vascular diseases	H. Hematologic disease
C. Infectious diseases	I. Trauma
D. Allergic manifestations	J. Psoriasis
E. Anaphylactoid purpura	K. Miscellaneous disorders
F. Neoplastic disease	

Laboratory Features

Listed in Table 3 are the laboratory studies that we found useful in diagnosis. The frequency of abnormality in the tests most commonly used is shown in Table 4. The most frequent abnormal test was an uncorrected elevated erythrocyte sedimentation rate (ESR-Wintrobe). It was seen most often in systemic onset disease. Only half of those patients presenting with polyarthritis or oligoarthritis had an abnormal ESR. In general,

patients with initially normal ESR's tended to maintain the same values during follow-up studies. Thus, a normal ESR does not exclude the diagnosis of JRA. Leukocytosis was often observed with systemic involvement but rarely found in pauciarticular disease. Thrombocytosis which is frequently encountered in patients with JRA, has been associated with a poorer prognosis.¹² Platelet determinations were useful in our experience for separating JRA patients from those patients with acute leukemia whose symptoms mimic those of JRA.¹³ Thrombocytosis was unusual in pauciarticular disease. Anemia was observed almost exclusively in systemic onset JRA (20%) and was not found in oligoarthritis. Resolution of the anemia spontaneously followed remission of disease and in our experience represented an excellent prognostic sign.

Diffuse hypergammaglobulinemia was present in 21% of our patients. However, three patients with

hypogammaglobulinemia and one patient with no detectable IgA in her serum presented with JRA.¹⁴

A clinically useful assay for IgG-rheumatoid factor suspected to be present in the serum of patients with JRA is not yet available. The commercially available latex-agglutination procedure for IgM-rheumatoid factor detected this antiglobulin in about 10% of our patients, predominantly the adolescent-onset population. Antinuclear antibodies were present as anti-DNP in 21% of our polyarthritic patients. Anti-deoxyribonucleic acid (anti-DNA) was found only in patients with systemic lupus erythematosus.

Blood and bone or joint cultures were important in distinguishing JRA from osteomyelitis or septic arthritis. Four percent of our patients presenting as JRA were found to have pyogenic arthritis or osteomyelitis.

Concepts of Therapy

Therapy of JRA involves physical and emotional support to the child and family as well as appropriate medical management. The goal of medical therapy consists of (a) alleviation of pain, (b) suppression of inflammation through the use of the safest, most effective drug for the briefest period possible, (c) prevention of ongoing joint destruction, and (d) maintenance of the best possible joint function pending remission of disease activity.

Of pharmacological agents effective in the treatment of JRA, salicylates most closely fit these goals. Aspirin has the additional benefit of being the least expensive remedy. Although gastric intolerance was rarely encountered, initial

TABLE 3. — Laboratory Tests Useful in Juvenile Rheumatoid Arthritis.

Tests Usually Obtained	Adjunctive Tests
Sedimentation Rate	Serum Transaminase
White Blood Count with Smear	Creatine Phosphokinase
Platelet Count	Australian Antigen Assay
Hematocrit	Quantitative Immunoglobulins
Rheumatoid Factor Assay	Streptococcal Antibody Tests
Antinuclear Antibody Screen	Coomb's Test
Urinalysis	Antibody to Extractable Nuclear Antigen

Table 4. — Frequency of Abnormal Laboratory Values in Patients with Subtypes of Juvenile Rheumatoid Arthritis.

Onset	ESR ¹	Thrombocytosis ²	Rheumatoid Factor	Anti-DNP ³
Systemic	57/78 ⁴ (73%)	36/63 (57%)	7/68 (10%)	6/70 (9%)
Polyarthritis	14/32 (59%)	12/24 (50%)	2/27 (7%)	6/29 (21%)
Pauciarticular Disease	15/27 (56%)	7/18 (59%)	3/26 (8%)	3/26 (12%)

1. Erythrocyte Sedimentation Rate-Wintrobe: >20 mm/hr, uncorrected

2. >400,000/cu mm

3. Anti-deoxyribonucleoprotein

4. Number abnormal/Number tested (percentage abnormal)

TABLE 5. — Drug Therapy of Juvenile Rheumatoid Arthritis.

Therapy	Number Treated ¹	Good Response	Poor/No Response
Salicylates (oral)	129	115 (89%)	14 (11%)
Corticosteroids	17	4 ² (24%)	13 (76%)
Gold Salts	7	3 (43%)	4 (57%)
Cytosan	2	2 (100%)	0
None ³	20	20 (100%)	0

1. Includes individuals in each category who received different therapeutic agents after failure to respond to salicylates.
2. All four had systemic disease with polyserositis.
3. All 20 patients who received no drug therapy had very mild pauciarticular disease.

noncompliance was a major problem. It was solved through patient and parental education. Explanation of the anti-inflammatory activity of aspirin as opposed to the other antipyretic-analgesic combinations was always undertaken. The unique ability of salicylates, as opposed to steroids or the newer propionic acid derivatives,¹⁵ to provide symptomatic relief and ultimately reverse joint deterioration was also emphasized to the parents.

One hundred twenty-nine (89%) of our 145 patients who took aspirin responded completely to adequate salicylate therapy (Table 5). The remaining 11% had an incomplete response necessitating additional modes of therapy. Therapeutic serum salicylate was kept at a level between 20-30 mg/dl. These levels were generally achieved through the use of 75-100 mg/kg/day in young children (less than 25 kg) and 50-75 mg/kg/day in the older child. Doses were divided so that they could be taken with three meals during the day and a bedtime snack. This regimen yielded adequate serum levels and eliminated gastric discomfort. As documented previously,¹⁶ buffered aspirin resulted in variable serum levels, most likely related to poor absorption and/or increased excretion.

Hepatitis, secondary to salicylate therapy, is being recognized with increasing frequency. This complication became manifest primarily by elevation of serum transaminase levels.¹⁷ Elevated

levels were observed in two of our systemic onset JRA patients prior to receiving salicylate. This observation confirms a previous report of hepatitis association with JRA.¹⁸ Patients with JRA of the systemic onset who received aspirin were more likely to have transaminase elevations than the other forms of JRA. Transaminase levels as high as 2000-3000 units were encountered particularly in patients with serum salicylate levels exceeding 30 mg/dl. These high transaminase levels usually started declining toward normal within 48 hours after stopping or lowering the salicylate dose. Salicylate-associated hepatitis was handled by discontinuing or lowering the salicylate dosage until a significant decrease in transaminase levels was observed. If patients were asymptomatic, they were then maintained on this smaller dose.

Secondary therapeutic agents included gold, prednisone and cyclophosphamide. All these agents are adjuncts to salicylate. Gold salt (Myochrysine) was used in the treatment of seven patients with aspirin-refractory arthritis and in our experience produced a mean duration of remission of 18 months. Gold salts were maintained at a dose of 1 mg/kg, given once monthly during remissions. Relapses occurred in six of the seven cases. Proteinuria and/or hematuria were the most frequent complications of gold salt therapy. Prednisone was useful topically in the management of iridocyclitis. Steroids were given intra-articularly to seven patients with monoarticular arthritis and resulted in an excellent clinical response. Systemic steroids were initiated in our clinic only for acute pericarditis. Most physicians² agree that systemic steroids have no other indication in the therapy of JRA. Nonsteroidal anti-inflammatory agents were not used in our pediatric patients. Two patients having poor response to aspirin, gold and steroid therapy were treated satisfactorily with cyclophosphamide. Though this drug has serious potential toxicity including the potential for metaplastic disease at later dates, no toxicity was documented in our cases. However, because the reported incidence of short and long-term toxicity are quite high,^{19,20} this drug is not recommended for random use in children with this disorder.

Initial evaluation for measurement of joint range of motion and muscle strength is useful in the majority of cases. The therapists are instrumental in developing an individualized home program for maintenance of joint mobility and strengthening weak muscle groups. Motivation was best achieved in our patients by emphasizing peer group and family activities relating to the specific areas of

rheumatoid involvement. Swimming was most often prescribed, being unique in allowing range of motion without weight-bearing to improve muscle strength. Certain games that patients could participate in were more practical than specific exercises for children. Progressive physical education classes were encouraged and physical restriction discouraged in patients whose disease was under control. Patients with severe muscle weakness, joint instability or subluxation of the cervical spine were restricted from participating in contact sports.

Most of our patients had mild symptoms and did exceptionally well during three-year mean follow-up. Active disease was present generally less than two years. Only four of our patients have significant residual joint destruction. Common factors relating to suboptimal therapy included internal family disturbances and parental noncompliance to the recommended therapeutic program. Others have suggested that a minimum of 10-15% JRA patients will have significant residual disease. Percentage of crippling disability tends to increase with long term follow-up.^{5,21} Our experience suggests that a multidisciplinary approach to the therapy of JRA in patients from this geographic area may be better than that reported from other centers. However, longer follow-up is indicated to adequately assess this point.

Future Considerations

While the etiology of JRA is uncertain, much current research has focused on the role of the host immunological response to a possible infectious agent.²² There is increasing evidence for a viral etiology in other collagen diseases, i.e. systemic lupus erythematosus and polyarteritis nodosa, which should allow development of approaches to study the role of viral agents in rheumatoid arthritis. Attention has now shifted toward a possible abnormal host immunological response in the pathogenesis of rheumatoid disease. Recent evidence shows a strong correlation with the histocompatibility antigen B27 in patients with ankylosing spondylitis and adolescent boys with pauciarticular JRA.²³ The role of this and other histocompatibility antigens in collagen-vascular disorders and the relationship by genetic linkage to a possible immune response locus in humans is being pursued.

Support for this type of investigative work has long been a goal of the Arthritis Foundation. The Shriners have now taken an interest in children with this disease. Supplementation of their efforts

culminated with the signing into law of the "National Arthritis Act of 1974." While JRA accounts for less than 7% of rheumatoid arthritis in this country, the fact that one can achieve a remission leading to a fully productive life in these children deserves special attention. Perhaps the correct emphasis can be placed on this disease through efforts such as the First Conference on the Rheumatic Diseases in Children held in Park City, Utah in the spring of 1976.⁶ It was our concern for these children that led us to establish a special clinic for the management of the disorder and resulted in the experience reported here.

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Cyanosis Due to Methemoglobinemia

Case Report

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Abstract: Methemoglobinemia is a rare condition which occurs when the concentration of Methemoglobin (MHB) within circulating erythrocytes is increased above a normal level of about 2%. It may arise as a result of an hereditary deficiency of Diphosphopyridine Nucleotide (DPNH)-Diaphorase, an inheritance of an abnormality of the globin portion of the hemoglobin molecule, or may be acquired when certain substances oxidize hemoglobin directly or indirectly. Methemoglobinemia should be considered in the differential diagnosis of cyanosis specially when symptoms and signs of cardiopulmonary disease are lacking or minimal. I am reporting a recent case with a brief review of the current literature.

Case Report

An 11-month-old white male had been in good health until cough, nasal discharge, diarrhea and fever developed five days prior to admission. His private physician treated him with penicillin, paregoric and an oral decongestant composed of phenylephrine and chlorpheniramine. On the fifth day of illness, respiratory distress and cyanosis developed and he was referred to Variety Children's Hospital.

Physical examination revealed a well-developed but cyanotic and dyspneic infant. There was no obvious evidence of cardiopulmonary disease. Despite 100% oxygen by mask, cyanosis persisted. Arterial blood, drawn for blood gases, was noted to be chocolate brown in color. This color remained after shaking the blood in air. Blood gases showed: O₂ saturation: 50%, PO₂:26; PCO₂:28; PH:7.43; HCO₃:18.8. A chest roentgenogram on admission revealed minimal right upper lobe infiltrate, which cleared after three days. The patient was given methylene blue intravenously 1.5 mg/kg. with prompt relief of the cyanosis. Oxygen administration was discontinued and arterial blood was drawn again which was now bright red in color. Arterial blood gas determination showed O₂ saturation: 92% PO₂:69; PCO₂:21; PH:7.54; HCO₃:20.

The patient was discharged in good health three days later. MHB level and hemoglobin electrophoresis were normal before discharge. MHB level before administration of methylene blue was not measured. Agents known to cause methemoglobinemia have been sought and not found. These agents are listed later in the review.

Review

Normally the iron of both oxygenated and deoxygenated hemoglobin is in the divalent state (ferrous), which is essential for oxygen transportation. Oxidation of hemoglobin iron to the trivalent state (HB- ferric iron) yields MHB which is nonfunctional (it cannot bind oxygen) and imparts a chocolate hue to the blood. Erythrocytes normally contain MHB, but the intra-erythrocytic MHB reducing system maintains its concentration at about 2% of the total hemoglobin. This system consists of: DPNH (NADH)-diaphorase, TPNH (triphosphopyridine nucleotide) -diaphorase, ascorbic acid and glutathione. Among these, DPNH-diaphorase is by far the most active.¹

In hereditary methemoglobinemia with a recessive pattern of inheritance, there is complete absence of DPNH-diaphorase. The normally produced MHB is not reduced effectively to hemoglobin and it accumulates in abnormal levels. Most cases reported in the United States have occurred in Alaskan Eskimos and Navajo Indians.²

The characteristic clinical features are the presence of a slate-grey type of cyanosis without obvious cardiopulmonary disease. Cyanosis often has been present from birth. Some patients with hereditary methemoglobinemia have undergone cardiac catheterization because of the mistaken diagnosis of congenital heart disease. MHB concentration in this type of methemoglobinemia usually does not exceed 40% of total hemoglobin. In addition to cyanosis, there is often dyspnea on exertion. Mental retardation has been found in about 10% of the reported cases, but a cause and effect relationship has not been established.³

In hereditary methemoglobinemia with a dominant pattern of inheritance (hemoglobin M disease), there is an abnormality of the globin portion of the hemoglobin molecule. The MHB reducing system is intact but is unable to reduce methemoglobin M to hemoglobin M because of the abnormal amino acid residues appearing in the

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globin chain of hemoglobin.¹ Hemoglobin M disease is the most common hemoglobinopathy in Japan.² Few cases have been reported in the United States.

With acquired methemoglobinemia abnormal levels of MHB may accumulate in the blood of healthy persons by exposure to oxidants, both direct and indirect.

Direct Oxidants:

1. Nitrites and nitrates

Occasional fatalities have occurred from milk prepared by mixing the dried or concentrated product with well water high in nitrates, (GI flora reduce nitrate to nitrite).

2. Chlorates and quinones

Indirect Oxidants

The following agents are capable of producing MHB only in vivo and not in vitro, presumably by conversion to active intermediate oxidant compounds:

1. Sulfonamides
2. Acetanilide, phenacetin and acetaminophen
3. Aniline Dyes (diaper marking ink, dye blankets) and naphthalene
4. Benzocaine, lidocaine and resorcin^{2,4,7}

Clinical Presentation

Symptoms and signs vary depending on the concentration of MHB in the blood. Concentrations of 15-25% produce only cyanosis. Concentrations of 35-45% produce cyanosis plus exertional dyspnea, headache, fatigue and tachycardia. Concentrations over 50% produce lethargy and stupor and concentrations of 70% or more are lethal.

Laboratory Diagnosis

1. Gross examination

A sample of blood should be inspected for color. MHB imparts a chocolate hue to the blood and this color persists after shaking the blood in air. If this bedside test is positive in acute cases, the diagnosis of methemoglobinemia should be made with immediate institution of treatment.

2. Spectroscopy

The blood is diluted with distilled water 1:10 and examined with a hand spectroscope. MHB produces a dark absorption band at 632 millimicrons which is abolished by adding cyanide. Quantitative measurement of MHB can be obtained spectrophotometrically.

3. Hemoglobin M can be identified by hemoglobin electrophoresis.
4. The DPNH-diaphorase is measured using the dye-linked enzyme assay method.^{2,3}

Treatment

Acquired methemoglobinemia

Treatment of mild cases consists of avoiding exposure to the offending agent. Intravenous methylene blue 1-2 mg/kg is the drug of choice in moderate and severe cases; it will promptly eliminate both MHB and Cyanosis.^{3,7} The same dose of methylene blue can be repeated only once after one hour. It should not be used in G-6-P-D deficient patients.

Hereditary Methemoglobinemia

In hereditary methemoglobinemia associated with DPNH-diaphorase deficiency treatment is for cosmetic reasons only. Methylene blue in daily oral doses of 3 mg/kg or ascorbic acid 200-500 mg/day will usually maintain the concentration of MHB below 10% and will alleviate the cyanosis as long as therapy is continued.

Hemoglobin M disease will not respond to administration of methylene blue or ascorbic acid. Fortunately treatment is not necessary because the congenital cyanosis is mild and not associated with disability.

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The Diencephalic Syndrome With Cerebrospinal Fluid Pleocytosis

J. Richard Gunderman, M.D.

ABSTRACT: A five-week-old black male presented with vomiting from birth, pleocytosis of the cerebrospinal fluid, and pyloric stenosis. Euphoria, nystagmus, optic atrophy, progressive subcutaneous fat wasting, and upper motor neuron abnormalities subsequently developed. An anterior hypothalamic tumor was discovered.

Many children present with complaint of failure to thrive. The diagnostic possibilities cover a wide spectrum ranging from intestinal malabsorption or obstruction to maternal deprivation. The patient described in this report exemplifies part of this spectrum and, in fact, defies the laws of parsimony, demonstrating two distinct etiologies for the presenting symptoms.

Case Report

A five-week-old black male was admitted to the Marion County General Hospital on March 5, 1974 because of failure to thrive secondary to vomiting. The patient was the product of a pregnancy complicated by the mother (G6P4) falling down a flight of stairs at seven months. There was no apparent intrauterine distress secondary to the accident. At delivery (40 weeks) the amniotic fluid was meconium stained and the patient required oxygen. The birth weight was seven pounds eight ounces. He was released from the newborn nursery at seven days of age and weighed seven pounds seven ounces. Vomiting beginning in the nursery persisted after discharge. He was re-admitted at five weeks of age with an increase in vomiting, now projectile in nature, and was described as a "good" baby to the extent of needing to be awakened for feedings.

Pertinent findings on initial physical examination included: Admitting weight eight pounds one ounce; head circumference

37 cm; small anterior fontanel; no bruit; eyes, pupils equal; funduscopic, normal; abdomen, no organomegaly. After feeding peristaltic waves were detected. No palpable "olive" deformity was found.

Initial neurologic examination revealed no cranial nerve abnormalities but several myoclonic jerks were noted. Transillumination of the head was normal as well as subdural taps. The motor examination revealed normal tone with muscle stretch reflexes being 2+ and symmetric. The patient was somnolent but arousable. Nystagmus was not present.

CBC, platelets, electrolytes, glucose, calcium, phosphorus, BUN, SGOT, and LDH were within normal limits; bilirubin total 4.0 mg%, indirect 3.4 mg%; alkaline phosphatase 254 IU; CSF routine results in Table 1. CSF cytology failed to reveal tumor cells, but immunoelectrophoresis revealed an increased protein with an elevation in gamma globulin of 25.50 (normal 10.40 + (2S) 3.42) compatible with degenerative CNS disease. Initial lumbar puncture revealed significant polymorphonuclear pleocytosis along with a marked elevation in protein, certainly not explainable by the pyloric obstruction. Congenital syphilis and tests for intrauterine infections, viz, cytomegalic inclusion disease and toxoplasmosis, proved negative. All cultures and smears of the cerebrospinal fluid, including fungal and acid fast bacilli, were negative. Urine for amino acids failed to reveal any abnormalities. Subsequent diagnostic possibilities centered around CSF pleocytosis.

The patient was initially treated for possible bacterial meningitis, i.e., ampicillin 200 mg/kg/day and kanamycin 12.5 mg/kg/day. When all cultures showed no bacterial growth, antibiotics were discontinued. With the more common etiologies of CSF pleocytosis virtually excluded, other diagnostic possibilities were entertained, viz, demyelinating disease and mass lesions. It was at this time that the patient, approximately eight weeks of age, demonstrated signs of a diencephalic syndrome including "eager overalertness," euphoria, with a marked disinterest in pain, pronounced subcutaneous fat loss, wandering nystagmus with early optic atrophy, and spasticity. Chest x-ray and five views of the skull were normal. Upper GI series findings were diagnostic of pyloric stenosis.

The patient underwent pyloromyotomy on March 7 and a

Table 1. — CSF Exam Results.

Date	RBC's	WBC's	Polys%	Lymphs%	Mono%	Sugar mg/dl	Protein mg/dl
3/6	8	119	78	20	2	65	548
3/9	319	27	26	64	10	66	807
3/17	14	46	40	25	35	62	603
4/1	8,800	1,120	16	70	14	68	1,320
4/10	105	378	3	84	13	79	1,460

definite mass was demonstrated. He tolerated this procedure well; however, vomiting persisted. A repeat upper GI series demonstrated normal passage of contrast material through the pylorus. A brain scan revealed a large tumor in the area of the hypothalamus and a ventriculogram showed a large mass in the anterior third ventricle (Figs. 1, 2).

The patient underwent a right frontal craniotomy which

revealed a cystic tumor involving most of the hypothalamic area and the optic nerves bilaterally. Partial surgical removal was performed and he tolerated the procedure well. Pathological diagnosis was astrocytoma (Fig. 3). Subsequently cobalt 60 teletherapy was begun for a total 5000 rads midline tumor dose. The patient was discharged on June 14 and did well during the following six months, then was lost to follow-up examination.



Fig. 1. — Two views of brain scan.

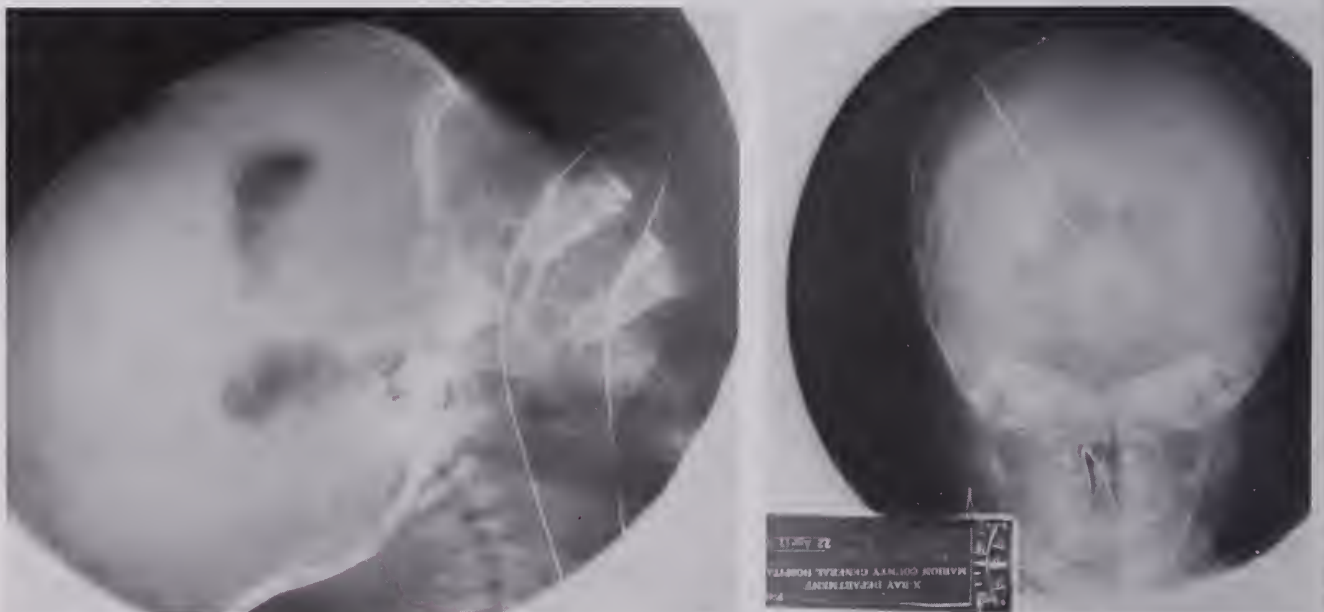


Fig. 2. — (a) Lateral view of ventriculogram. (b) P-A view.

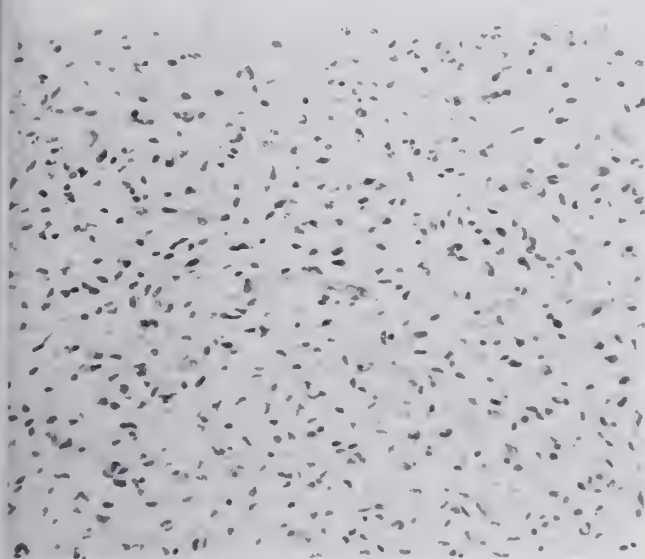


Fig. 3. — Surgical specimen.

Discussion

This patient had a radiologically diagnosed and surgically corrected lesion, pyloric stenosis, but there was no improvement in the symptom, vomiting. The second lesion was subsequently diagnosed.

The diencephalic syndrome was first recognized as a clinical entity in 1951 when Russell summarized his findings in five children.¹ The major features are emaciation, with marked subcutaneous fat loss, initial growth acceleration, motor overactivity, and euphoria. Other features include nystagmus, visual disturbances, various fundoscopic changes, vomiting, autonomic dysfunction, pallor without anemia, hypoglycemia and hypotension. Goebel presented the initial case report in 132 and there have been 56 subsequent published cases.²⁻⁴⁸ This probably does not represent the true incidence of this syndrome, being more frequent than 56 cases would suggest.

Addy and Hudson reviewed the world literature in 1972 and found the age at onset of symptoms to be below six months in 62% (28/45), with the range between one month and three years.⁵ In the patient presented here, the symptom, vomiting, had its onset at birth although further findings were delayed until eight weeks of age.

The other facet was significant CSF pleocytosis and elevated protein. Menkes states that 70% of children with CNS tumors have elevated protein and that "pleocytosis occurs in only 30%."⁴⁹ "In general the pleocytosis is not striking and counts greater than 100 are uncommon."⁵⁰ Guillain and Verdun in

1911 first described the meningeal syndrome associated with a brain tumor (glioblastoma).⁵¹ Brown and Peyton reported three cases of brain tumor simulating meningitis.⁵² Daum and Navarro-Artiles reported nine cases of tumor presenting as an acute meningeal syndrome with signs of either CNS hemorrhage or aseptic meningitis.⁵³ Arnstein and Wedgewood reviewed the records of all children with CNS tumors listed in the Tumor Registry for the years 1946 to 1971 and reported that the overall number of cases presenting with the meningeal syndrome was 7.2%.⁵⁴ Pleocytosis occurred in only one of 66 children with an astrocytoma; however, 40% (2/5) of pinealomas and approximately 15% of medulloblastomas (5/34) and ependymomas (4/26) presented with the meningeal syndrome.

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Neonatal CARE Line Speeds Treatment of Newborn

A sophisticated communications system designed to refer Florida's critically ill newborn to a neonatal system as quickly as possible has become operational.

The Neonatal Communication and Referral Line (CARE) is based at Tampa General Hospital and is a vital adjunct to the State's network of hospital neonatal units, according to Edmund A. Egan, M.D., a neonatologist at the University of Florida College of Medicine.

Funding was provided by the American Heart Association, Florida Affiliate, its Broward County Chapter, the Friends of Children Foundation, and Florida's Children's Medical Services Program. Louis B. St. Petery, M.D., of Tallahassee, and Howard Harris, M.D., of Tampa, coordinated CARE's development.

CARE can provide up-to-the-minute information on available beds at the seven existing Regional Neonatal Intensive Care Centers located at Pensacola, Jacksonville, Gainesville, Tampa, Miami, Orlando, and St. Petersburg. Three more centers are planned for Palm Beach, Broward and Dade when funds become available.

Staffed around-the-clock, CARE includes one WATS line which will be used solely for maintaining a census of available beds in each center. Other incoming and outgoing WATS lines are used for physician communications.

Patching equipment allows the operator in the Tampa communications center to connect any physician calling through the system with any other party in the state, facilitating infant transport where multiple individuals are involved.



PLLP PRIORITY '77

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May 19, 1977

No. 4

THE FLORIDA LEGISLATURE HAS REENACTED FMA SPONSORED 1976 PROFESSIONAL LIABILITY LAWS WHICH WERE STRICKEN BY A CIRCUIT COURT AND ARE NOW PENDING BEFORE THE FLORIDA STATE SUPREME COURT.

This includes provisions for:

1. Application of collateral sources in jury trials, as a direct offset.
2. Definition of medical professional negligence.
3. Definition of medical expert witnesses.
4. Prohibit use of res ipsa loquitur doctrine in professional negligence actions.
5. Structured pay-out of future damages.
6. A Remittur-Additur provision which provides for the judge to lower or raise an award if, in his opinion, the jury verdict is excessive or inadequate.

There were technical amendments to the 1976 law regarding collateral sources, structured settlements, and Mediation Panels. (Panel members are now entitled to \$100 per day compensation for service on a Mediation Panel.)

The Legislature also reenacted a provision which limits assessability of the Patient's Compensation Fund to one annual premium.

The FMA Priority Program for 1977 which provides for an Absolute Two-Year Statute of Limitations and Recovery of Defense Costs is still pending in the Legislature.



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ACCREDITED BY THE J. C. A. H.

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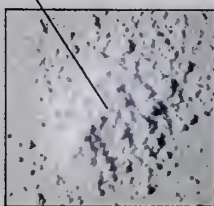


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2 caps
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**the only sinusitis formula offering an extra-strength dose of
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Aspirin isn't best for children

(When they need it most, they tolerate it least.)



Children who are dehydrated (due to fever, diarrhea or vomiting) are particularly prone to aspirin toxicity, even at therapeutic doses.^{1a} This is of special concern in infants and young children where repeated therapeutic doses of aspirin can cause severe metabolic disturbances.^{1b}

TYLENOL[®] acetaminophen products have not been associated with electrolyte imbalance or acid-base changes, and therefore are unlikely to produce such a toxic reaction, even in the dehydrated child.

And, equally important, numerous investigators have reported TYLENOL acetaminophen to be as effective as aspirin for relief of fever and pain.^{1c, 2, 6}

So why risk aspirin complications in children of any age? Recommend TYLENOL elixir, drops or chewable tablets... to effectively reduce fever and relieve pain when they need it most.

Chewable tablets: 120 mg. acetaminophen
Elixir: 120 mg. acetaminophen per 5 ml. (alcohol 7%)
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Precautions and Adverse Reactions: If a rare sensitivity reaction occurs, the drug should be stopped. TYLENOL acetaminophen at recommended doses has rarely been found to produce any side effects.

References: 1. Goodman, L.S., and Gilman, A., eds.: The Pharmacological Basis of Therapeutics, Fifth Edition, New York, The Macmillan Company, 1975 (a) p. 335, (b) p. 336, (c) p. 344. 2. Eden, A.M.: Am. J. Dis. Child. 114:284-287 (Sept.) 1967. 3. Mintz, A.A.: J. Ky. Acad. Gen. Pract. 5:26-31 (Jan.) 1959. 4. Colgan, M.T., and Mintz, A.A.: J. Pediatr. 50:552-555 (May) 1957. 5. Saunders, D.C.: Practitioner 183:335-338 (Sept.) 1959. 6. Reuter, S.H., and Montgomery, W.W.: Arch. Otolaryngol. 80:214-217 (Aug.) 1964. © McN 1977

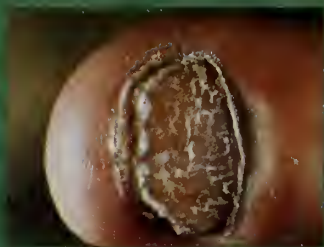
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aspirin complications..
and just as effective
for fever and pain**



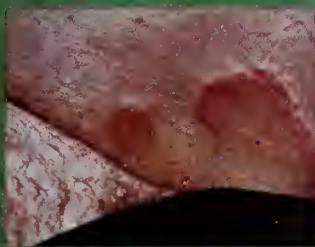
When Griseofulvin is indicated...



TINEA PEDIS*



TINEA UNGUIUM*



TINEA CRURIS*



TINEA CAPITIS*

*Also *Tinea barbae* and *Tinea corporis* when caused by fungi from genera known to be sensitive to griseofulvin.

Gris-PEG[®] (griseofulvin ultramicrosize) Tablets 125 mg offers effective therapy with 1/2 the dose.[†]

- Can be taken on an empty stomach
- Absorption nearly complete without fatty meals
- Reduced cost for patients
- Once-a-day or b.i.d. dosage

[†]250 mg of Gris-PEG[®] provides plasma levels equivalent to those obtained with 500 mg microsize-griseofulvin. This improved absorption permits the oral intake of half as much griseofulvin but there is no evidence, at this time, that this confers any significant clinical difference in regard to safety or efficacy.



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Please see other side for full prescribing information.

Gris-PEG[®]

(griseofulvin ultramicrosize) Tablets
125 mg
The 1/2 dose griseofulvin.

DESCRIPTION

Griseofulvin is an antibiotic derived from a species of *Penicillium*.

Gris-PEG is an ultramicrocrystalline solid-state dispersion of griseofulvin in polyethylene glycol 6000.

Gris-PEG tablets differ from griseofulvin (microsize) tablets USP in that each tablet contains 125 mg of ultramicrosize griseofulvin biologically equivalent to 250 mg of microsize griseofulvin.

ACTION

Microbiology: Griseofulvin is fungistatic with *in vitro* activity against various species of *Microsporum*, *Epidermophyton* and *Trichophyton*. It has no effect on bacteria or other genera of fungi.

Human Pharmacology: The peak plasma level found in fasting adults given 0.25 g of Gris-PEG occurs at about four hours and ranges between 0.37 to 1.6 mcg/ml.

Comparable studies with microsize griseofulvin indicated that the peak plasma level found in fasting adults given 0.5 g occurs at about four hours and ranges between 0.44 to 1.2 mcg/ml.

Thus, the efficiency of gastrointestinal absorption of the ultramicrocrystalline formulation of Gris-PEG is approximately twice that of conventional microsize griseofulvin. This factor permits the oral intake of half as much griseofulvin per tablet but there is no evidence, at this time, that this confers any significant clinical differences in regard to safety and efficacy. Griseofulvin is deposited in the keratin precursor cells and has a greater affinity for diseased tissue. The drug is tightly bound to the new keratin which becomes highly resistant to fungal invasions.

INDICATIONS

Gris-PEG (griseofulvin ultramicrosize) is indicated for the treatment of the following ringworm infections.

Tinea corporis (ringworm of the body)
Tinea pedis (athlete's foot)
Tinea cruris (ringworm of the thigh)
Tinea barbae (barber's itch)
Tinea capitis (ringworm of the scalp)
Tinea unguium (onychomycosis; ringworm of the nails)

when caused by one or more of the following genera of fungi:

Trichophyton rubrum
Trichophyton tonsurans
Trichophyton mentagrophytes
Trichophyton interdigitalis
Trichophyton verrucosum
Trichophyton megnini
Trichophyton gallinae
Trichophyton crateriform
Trichophyton sulphureum
Trichophyton schoenleinii
Microsporum audouinii
Microsporum canis
Microsporum gypsum
Epidermophyton floccosum

NOTE: Prior to therapy, the type of fungi responsible for the infection should be identified.

The use of the drug is not justified in minor or trivial infections which will respond to topical agents alone.

Griseofulvin is not effective in the following:

Bacterial infections
Candidiasis (Moniliasis)
Histoplasmosis
Actinomycosis
Sporotrichosis
Chromoblastomycosis
Coccidioidomycosis
North American Blastomycosis
Cryptococcosis (Torulosis)
Tinea versicolor
Nocardiosis

CONTRAINDICATIONS

This drug is contraindicated in patients with porphyria, hepatocellular failure, and in individuals with a history of sensitivity to griseofulvin.

WARNINGS

Prophylactic Usage: Safety and Efficacy of Griseofulvin for Prophylaxis of Fungal Infections Has Not Been Established.

Animal Toxicology: Chronic feeding of griseofulvin, at levels ranging from 0.5-2.5% of the diet, resulted in the development of liver tumors in several strains of mice, particularly in males. Smaller particle sizes result in an enhanced effect. Lower oral dosage levels have not been tested. Subcutaneous administration of relatively small doses of griseofulvin, once a week, during the first three weeks of life has also been reported to induce hepatoma in mice. Although studies in other animal species have not yielded evidence of tumorigenicity, these studies were not of adequate design to form a basis for conclusions in this regard.

In subacute toxicity studies, orally administered griseofulvin produced hepatocellular necrosis in mice, but this has not been seen in other species. Disturbances in porphyrin metabolism have been reported in griseofulvin treated laboratory animals. Griseofulvin has been reported to have a colchicine-like effect on mitosis and cocarcinogenicity with methylcholanthrene in cutaneous tumor induction in laboratory animals.

Usage in Pregnancy: The safety of this drug during pregnancy has not been established.

Animal Reproduction Studies: It has been reported in the literature that griseofulvin was found to be embryotoxic and teratogenic on oral administration to pregnant rats. Pups with abnormalities have been reported in the litters of a few bitches treated with griseofulvin. Additional animal reproduction studies are in progress.

Suppression of spermatogenesis has been reported to occur in rats, but investigation in man failed to confirm this.

PRECAUTIONS

Patients on prolonged therapy with any potent medication should be under close observation. Periodic monitoring of organ system function, including renal, hepatic and hematopoietic, should be done.

Since griseofulvin is derived from species of *Penicillium*, the possibility of cross sensitivity with penicillin exists; however, known penicillin-sensitive patients have been treated without difficulty.

Since a photosensitivity reaction is occasionally associated with griseofulvin therapy, patients should be warned to avoid exposure to intense natural or artificial sunlight. Should a photosensitivity reaction occur, lupus erythematosus may be aggravated.

Griseofulvin decreases the activity of warfarin-type anticoagulants so that patients receiving these drugs concomitantly may require dosage adjustment of the anticoagulant during and after griseofulvin therapy.

Barbiturates usually depress griseofulvin activity and concomitant administration may require a dosage adjustment of the antifungal agent.

ADVERSE REACTIONS

When adverse reactions occur, they are most commonly of the hypersensitivity type such as skin rashes, urticaria, and rarely, angioneurotic edema, and may necessitate withdrawal of therapy and appropriate countermeasures. Paresthesias of the hands and feet have been reported rarely after extended therapy. Other side effects reported occasionally are oral thrush, nausea, vomiting, epigastric distress, diarrhea, headache, fatigue, dizziness, insomnia, mental confusion and impairment of performance of routine activities.

Proteinuria and leukopenia have been reported rarely. Administration of the drug should be discontinued if granulocytopenia occurs.

When rare, serious reactions occur with griseofulvin, they are usually associated with high dosages, long periods of therapy, or both.

DOSAGE AND ADMINISTRATION

Accurate diagnosis of the infecting organism is essential. Identification should be made either by direct microscopic examination of a mounting of infected tissue in a solution of potassium hydroxide or by culture on an appropriate medium.

Medication must be continued until the infecting organism is completely eradicated as indicated by appropriate clinical or laboratory examination. Representative treatment periods are—*tinea capitis*, 4 to 6

weeks; *tinea corporis*, 2 to 4 weeks; *tinea pedis*, 4 to 8 weeks; *tinea unguium*—depending on rate of growth—fingernails, at least 4 months; toenails, at least 6 months.

General measures in regard to hygiene should be observed to control sources of infection or reinfection. Concomitant use of appropriate topical agents is usually required particularly in treatment of *tinea pedis*. In some forms of athlete's foot, yeasts and bacteria may be involved as well as fungi. Griseofulvin will not eradicate the bacterial or monilial infection.

An oral dose of 250 mg of Gris-PEG (griseofulvin ultramicrosize) is biologically equivalent to 500 mg of griseofulvin (microsize), USP (see ACTION Human Pharmacology).

Adults: A daily dose of 250 mg will give a satisfactory response in most patients with *tinea corporis*, *tinea cruris* and *tinea capitis*. One 125 mg tablet twice per day or two 125 mg tablets once per day is the usual dosage. For those fungal infections more difficult to eradicate such as *tinea pedis* and *tinea unguium*, a divided daily dose of 500 mg is recommended. In all cases, the dosage should be individualized.

Children: Approximately 5 mg per kilogram (2.5 mg per pound) of body weight per day is an effective dose for most children. On this basis, the following dosage schedule for children is suggested:

Children weighing over 25 kilograms (approximately 50 pounds)—125 mg to 250 mg daily.

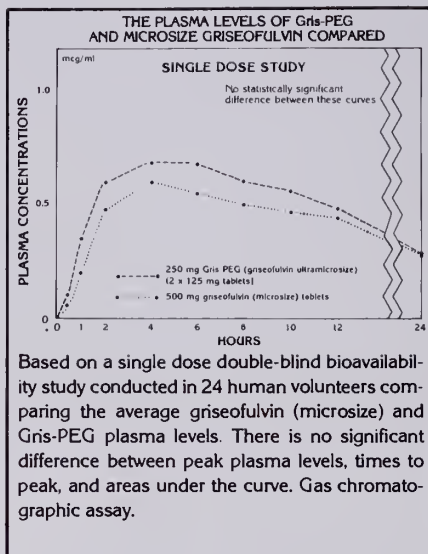
Children weighing 15-25 kilograms (approximately 30-50 pounds)—62.5 mg to 125 mg daily.

Children 2 years of age and younger—dosage has not been established.

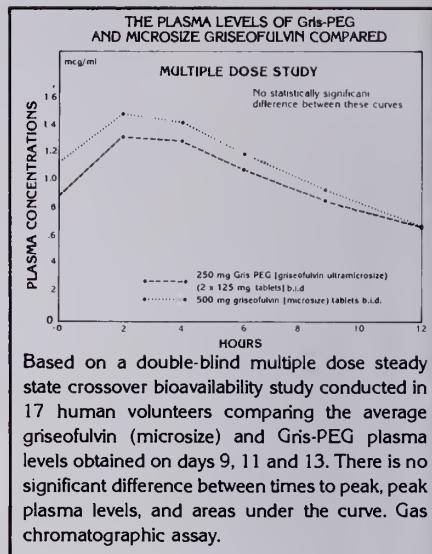
Dosage should be individualized, as is done for adults. Clinical experience with griseofulvin in children with *tinea capitis* indicates that a single daily dose is effective. Clinical relapse will occur if the medication is not continued until the infecting organism is eradicated.

HOW SUPPLIED

Gris-PEG (griseofulvin ultramicrosize) Tablets (white) differ from griseofulvin (microsize) tablets (USP) in that each tablet contains 125 mg of ultramicrosize griseofulvin biologically equivalent to 250 mg of microsize griseofulvin. Two 125 mg tablets of Gris-PEG are biologically equivalent to 500 mg of microsize griseofulvin. In bottles of 100 and 500 scored, film-coated tablets.



Based on a single dose double-blind bioavailability study conducted in 24 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels. There is no significant difference between peak plasma levels, times to peak, and areas under the curve. Gas chromatographic assay.



Based on a double-blind multiple dose steady state crossover bioavailability study conducted in 17 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels obtained on days 9, 11 and 13. There is no significant difference between times to peak, peak plasma levels, and areas under the curve. Gas chromatographic assay.

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The Art of Being a Doctor

What has gone wrong with the vaunted doctor-patient relationship which traditionally has been the prize - and pride - of organized medicine?

Medicine is in the midst of a crisis of human relations. Communication is breaking down between doctors and patients at a time when patients seek more personal attention. A preoccupied manner, perfunctory tone, and crowded waiting rooms, make many of them feel insecure and hesitant to seek their rightful share of sympathy, affection, understanding and guidance. The stresses of modern living intensifies their needs while the traditional sources of support have become weak, such as the family, schools and church.

The doctor-patient relationship is the most potent tool in healing illnesses which afflict the body but stem from the mind. Unfortunately, many physicians have little time to both ferret out organic disease and look beyond symptoms. Likewise, traditional patterns of practice have been affected profoundly by factors such as the growth of health insurance and extension of the government's role in the private care system. The result may be prescriptions for sedatives and tranquilizers and a dismal, costly trek from specialist to specialist.

Fragmentation of medical specialties has made doctors inextricably dependent upon each other and upon hospitals in order to give good medical care. Their compassion and intuitive skills are becoming waylaid by the scientist's act of analysis and integration. Yet, the profession still is haunted by an antiquated self-image of the dedicated individual healer who makes solitary rounds with a little black bag. Patients, more sophisticated today, find it increasingly difficult to reconcile the proclaimed dedication to selfless service with a

businesslike attitude toward making lots of money. They believe that most doctors have forgotten that the whole person is as important as the disease.

The doctor-patient relationship can be restored toward its previous warm status with compassion and efficient medical care, if all physicians play an active role in the humanization of private practice. While it is essential that we continue to refine and enlarge our scientific skills, so important for finding cures for the diseases that still plague mankind, we must not forget that patients are apprehensive people, needing reassurance from someone they know well and respect.

Doctors should learn that self-adulatory propaganda and publicity gimmicks are a poor substitute for genuine devotion to the welfare of their patients. They should recognize that medicine is not their private preserve but a profession in which all people have a vital stake. And they should realize that the patient has greatly changed along with a great deal in medicine.

The overriding challenge is to learn the proper proportion of art and science in medicine, of understanding and technology.

Increasingly in the future will be the responsibility of social medicine, not the same as socialized medicine, to plan for the welfare of society as a whole. At present in modern medicine, it will take great medical statesmanship to correct a major failure — the patient's sense of unrequited love.

Edward Pedrero Jr., M.D.
Tampa

Dr. Pedrero is a member of the Consulting Editorial Staff of the Journal and Editor of The Bulletin of the Hillsborough County Medical Association.



Louis C. Murray, M.D.

Our 101st President

Thomas B. Thames, M.D.

The 101st president of the Florida Medical Association is Dr. Louis C. Murray of Orlando, Florida.

Dr. Murray was born August 12, 1924, in Tulsa, Oklahoma and became a resident of Florida in 1942. He attended Villanova University where he obtained his Bachelor of Science degree in 1947. He received his Master of Science degree in 1948 from the University of Florida. He attended Hahnemann Medical College and received his M.D. degree in 1953, and then interned at Orange Memorial Hospital in Orlando, Florida, entering private practice in Orlando in 1954, where he continued to practice until the present. He is a family physician. Dr. Murray served in the United States Navy from 1942 to 1946.

He has continued to serve his community and state as a member of the Florida State Board of Regents from 1965 to 1973 and served as vice-chairman from 1967 to 1971. He has also served on the Governor's Commission on Urban Redevelopment in 1968 and the Florida Regional Medical Program as a director and member of the Executive Committee. Lou also served on the Florida State Comprehensive Health Planning Council from 1967 to 1970. He has been active in the Orlando Area Chamber of Commerce and the University Club of Orlando. He was on the Board of Directors of the Florida Council of the Blind and served on the Board of Directors of Fairvilla Combank; presently he serves on the Board of Directors of the Southeast National Bank.

Dr. Murray was recognized by Florida Technological University, 1974, with an honorary degree of Doctorate of Public Service. He has been recognized by the University of Florida with its

Outstanding Alumnus Award in 1976, and by the Knights of Columbus with their Man of the Year Award in 1966.

Since 1954, Lou has been a member of the American Medical Association and since 1955 a member of the American Academy of Family Physicians; he became a Diplomate in 1973. He served as president of the Florida Academy of Family Physicians 1966-67.

He served as president of the Orange County Medical Society in 1968, after holding many offices in his county society. Dr. Murray has served the Florida Medical Association as a member of the House of Delegates from 1960 to the present, as chairman of FLAMPAC from 1967 to 1969, on the Committee of 17, Blue Shield of Florida, 1966 to 1969, and as chairman of the Committee on National Legislation 1971 to present. He has been a member of the Board of Governors of the Florida Medical Association from 1971 to present. He is perhaps best known to most of us, however, for his years as vice-speaker and speaker of the House. His calm, reasoned and knowledgeable handling of Sturgis and the business of the House impressed all his colleagues. He was elected President-Elect of the Florida Medical Association in 1976.

Dr. Murray married the former Sue Spatafora, of Munroe, Louisiana in 1953, and they have six children, four sons and two daughters.

The members of the Florida Medical Association have continued their tradition of electing men of the highest caliber in selecting Dr. Louis C. Murray of Orlando as their new president.

- Dr. Thames, 1723 Lucerne Terrace, Orlando 32806.

Dr. Russell B. Carson Is Broward's "Doctor of the Year"



Dr. Carson

Russell B. Carson, M.D., Ft. Lauderdale urologist, has been cited by the Caducean Society as Broward County's "Doctor of the Year."

Dr. Carson was named the sixth recipient of the John P. Heideman Award, named for the late founding member and past president of the Caducean Society.

The award was made on the basis of Dr. Carson's "service in the practical day-by-day application of one's knowledge, energy, skill, concern and dedication to the enhancement of the ideals of medicine and of the health of his fellow man."

The Caducean Society was organized in 1970. Its 40-doctor membership is composed of no more than two physicians from each major specialty. It is dedicated to the advancement of medical science by the exchange of medical knowledge, principles and skills among practitioners of the different specialties.

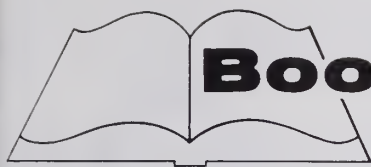
Dr. Carson was born at Frostproof and received his M.D. degree at Tulane University, Class of 1935. He has been active for many years within his specialty and in organized medicine.

A member of the American College of Surgeons, he is Secretary of the American Association of Clinical Urologists and is a former President of the Broward County Medical Association. For eight years he was President of Blue Shield of Florida.

Called Meeting of FMA House In Tampa, June 12

In compliance with the FMA Bylaws, there will be a Called Meeting of the House of Delegates at 10:00 a.m. Sunday, June 12, 1977, at the Holiday Inn (Airport) Tampa, Florida. The purpose of the Called Meeting shall be consideration of the FMA policy regarding national health insurance. The agenda shall be restricted to this subject.

The Called Meeting is at the request of Orange County Medical Society, Seminole County Medical Society, and Osceola County Medical Society. (Chapter IV, Section 3, of the FMA Bylaws requires the President to call a meeting upon the request of three or more county medical societies.)



Book Reviews

Book Review Editor
F. Norman Vickers, M.D.

The Doctor-Patient Relationship, Second Edition, by Kevin Browne, M.D. and Paul Freeling, M.D., 101 pages, Soft Cover. Price not stated. Churchill Livingstone, New York, 1976.

The authors, both general practitioners in England, have sought to revise this small book, first printed in 1967. They attempt to give insights into physician communications and illustrate with brief examples from their own practice.

Two short chapters on the use of sympathy interested me. The usual pleas for physicians to be more warm and sympathetic are presented. However, they also show the problems of unthinking sympathy administered by the physician. They also present gambits by the patient to manipulate the physician; one example is the use of tears by the female patient. The authors provide some warning signals so the physician can be alert for the beginning of a manipulative situation. Summing up, they state, "There are no harmful side-effects to the administration of sympathy, if it is directed to the correct area of disturbance, and if its continued administration is reconsidered each time the situation alters."

There are some perceptive suggestions about interviewing patients to get at the real problem, understanding the reason behind the symptom and making brief physician-patient encounters productive.

This small book is not a definitive text but it is succinct and without confusing terminology. It is recommended for those who wish to gain skill and insight toward improving relationships with their patients.

F. N. V.

Review of Medical Pharmacology, 5th Edition by Frederick H. Meyers, M.D., Ernest Jawetz, Ph.D. and Alan Goldfien, M.D., 740 Pages. Illustrated. Price \$12.50. Lange Medical Publications, Los Altos, California, 1976.

The stated purpose of the authors is to provide, in this fifth edition, an emphasis on those aspects of pharmacology that serve clinical needs of students and practitioners in the medical arts. In addition, they suggest a skeptical attitude toward all new drug claims and a critical re-examination of prescribing habits and drugs that have been used for years.

The contents are divided into sections on General Information, Autonomic and Cardiovascular Drugs, Central Nervous System Drugs, Systemic Drugs, Endocrine Drugs, Agents Used In The Treatment of Nutritional and Metabolic Derangements, Chemotherapeutic Agents, and Toxicology. These sections are divided into 66 chapters.

Pertinent information is given on drug administration, interactions, incompatibilities, physiological and pharmacological drug actions. The reader will usually find adequate information he needs, and if he wishes more, the bibliography will supply it. It is amazing that the publisher continues to keep down prices on his books year after year. This one is \$12.50 and considering the size and excellent paper upon which it is printed, one wonders how the publisher does it. I recommend the book to students or practitioners of the medical arts.

Perry A. Sperber, M.D.
South Daytona

Dr. Sperber is retired from the practice of Dermatology.

Books Received

Receipt of the following books is acknowledged. Medical readers interested in reviewing particular books are invited to address requests to the Book Review Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.

Live Longer Now, The First One Hundred Years of Your Life, by Jon N. Leonard, J. L. Hofer and N. Pritikin. 232 Pages. Illustrated. Price \$2.95. Grosset & Dunlap, New York, 1977.

The Live Longer Now Cookbook for Joyful Health and Long Life by John N. Leonard and Elaine A. Taylor. 368 Pages. Price \$12.95. Grosset & Dunlap, New York, 1977.

Lupus - The Body Against Itself by Sheldon Paul Blau, M.D. and Dodi Schultz. 112 Pages. Price \$5.95. Doubleday & Company, Inc., Garden City, N.Y., 1977.

How to Feed Your Hyperactive Child by Laura J. Stevens, George E. Stevens and Rosemary B. Stoner. 240 Pages. Price \$7.95. Doubleday & Company, Inc., Garden City, New York, 1977.

Social Responsibility: Journalism, Law, Medicine, Volume II, edited by Louis W. Hodges. 104 Pages. Price \$2.50. Washington and Lee University, Lexington, Virginia, 1976.

Correlative Neuroanatomy & Functional Neurology, 16th Edition by Joseph G. Chusid, M.D. 448 Pages. Illustrated. Price \$10.00. Los Altos, California, Lange Medical Publications, 1976.

Current Pediatric Diagnosis and Treatment, 4th Edition, by C. Henry Kempe, M.D., Henry K. Silver, M.D. and Donough O'Brien, M.D. 1,053 Pages. Illustrated. Price \$15.00. Los Altos, California, Lange Medical Publications, 1976.

Medicine In the Tropics, Diagnostic Pathways in Clinical Medicine, An Epidemiological Approach to Clinical Problems by B. J. Essex. 173 Pages. Illustrated. Price \$9.95. New York, Churchill Livingstone, 1977.

Current Obstetric & Gynecologic Diagnosis & Treatment by Ralph C. Benson, M.D. and Associate Authors. 912 Pages. Price \$16.00. Lange Medical Publications, Los Altos, Calif., 1976.

Growth, Maturation, and Aging by Tadayoshi Imaizumi. 118 Pages. Sugiyama-ku, Tokyo, Kagayama Press, 1976.

The Multiple Sclerosis Diet Book by Roy L. Swank, M.D., Ph.D. and Mary-Helen Pullen. 326 Pages. Price \$8.95. Doubleday & Company, Inc., Garden City, New York, 1977.

Currents In Alcoholism, Biological, Biochemical and Clinical Studies, Volume I edited by Frank A. Seixas, M.D. 495 Pages. Illustrated. Price \$19.50. New York, Grune & Stratton, 1977.

Currents In Alcoholism, Biological, Biochemical and Clinical Studies, Volume II edited by Frank A. Seixas, M.D. 548 Pages. Illustrated. Price \$19.50. New York, Grune & Stratton, 1977.

Southwestern Medical Dictionary, Spanish English, English Spanish, by Margarita Artschwager Kay with John D. Meredy/Wendy Redlinger and Alicia Quiroz Raymod. 217 Pages. Price \$3.75 (paper) \$9.50 (cloth). Tucson, Arizona, The University of Arizona Press, 1977.

Child Health In the Community, A Handbook of Social and Community Paediatrics edited by Ross G. Mitchell, M.D. 313 Pages. Price \$18.00. New York, Churchill Livingstone, 1977.

The Water Jump—The Story of Transatlantic Flight by David Beaty. 304 Pages. 140 Illustrations. Price \$10.00. Harper & Row, Publishers, Inc., New York, 1977.

DIRECTOR FAMILY PRACTICE RESIDENCY TRAINING PROGRAM

A six hundred bed major affiliated Hospital of the University Miami School of Medicine seeks a physician Board Certified in Family Practice, or a primary care specialty, with administrative capability to serve as the salaried Full Time Director of the Family Practice Residency Program located at Memorial Hospital, Hollywood, Florida; Candidate must be approved by and will receive a faculty appointment to the University of Miami, Department of Family Medicine. The Director is responsible for all of the activities of the Family Practice Residency Program, which now includes eight Residents in their last two years of training. Send curriculum vitae and salary requirements in confidence to: Administrator, Memorial Hospital, 3501 Johnson Street, Hollywood, Florida. Memorial Hospital is an equal opportunity employer.



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You may need extra protection against financial loss . . . when you're hospitalized by accident or illness. And that's exactly what you get when you enroll for coverage under the Hospital Money Plan, sponsored by your Florida Medical Association, Inc.

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Extra protection to help cover increasing medical care costs.

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In these uncertain days of inflationary tendencies, you need the reliable protection this Hospital Money Plan will help provide. You'll have extra protection against financial loss tomorrow. — For further information concerning the Plan, contact the Professional Insurance Management Company (PIMCO).

UNIVERSITY OF MIAMI SCHOOL OF MEDICINE
DEPARTMENT OF INTERNAL MEDICINE

FOURTH ANNUAL REVIEW COURSE

"Fundamental and Clinical Aspects of Internal Medicine"

Sheraton-Four Ambassadors Hotel

Miami, Florida

October 9-22, 1977

Directors: William J. Harrington, M.D., Eric Reiss, M.D., and Neal S. Bricker, M.D.

Program Coordinator: Jose S. Bocles, M.D.

This course is designed primarily for physicians who are preparing for initial certification or recertification in internal medicine. It will provide an intensive survey of those aspects of internal medicine which should be familiar to internists qualified for certification. Pertinent basic and core information followed by a survey of recent clinical advances needed for effective patient care will be presented. Printed texts, references and self-assessment questionnaires will be provided to all registrants, and audio-visual teaching aids will be available for self-instruction and reinforcement. This course will end one week prior to the recertification examination of the American Board of Internal Medicine, thereby providing time for assimilation.

Schedule

Week I — October 10-15, 1977

October	10	Gastroenterology & Hepatology
"	11	Cardiology
"	12	Hypertension & Body Fluids
"	13	Nephrology
"	14	Endocrinology
"	15	Oncology & Genetics

Week II — October 17-22, 1977

October	17	Hematology
"	18	Infectious Diseases & Immunology
"	19	Rheumatology
"	20	Pulmonary Diseases
"	21	Clinical Pharmacology, Dermatology, Toxicology & Environmental Medicine
"	22	Neurology & Psychiatry

Supervised CME Activities: 84 Hours Credit

As an organization accredited for continuing medical education, the University of Miami School of Medicine certifies that this continuing medical education offering meets the criteria for 84 credit hours in Category I of the Physician's Recognition Award of the American Medical Association, provided it is used and completed as designed.

Self-Instructional Materials: 64 Hours Credit

As an organization accredited for continuing medical education, the University of Miami School of Medicine certifies that when these continuing medical education materials are used as directed, they meet the criteria for 64 hours of credit in Category I for the Physician's Recognition Award of the American Medical Association.

Registration Fees: Entire Course (Oct. 10-22) \$500
Week I (Oct. 10-15) \$300
Week II (Oct. 17-22) \$300
Per day (minimum of 3 days) \$ 70

Checks payable to: U/Miami Internal Medicine Review Course.

Minimum and maximum enrollment has been established for this course. Please register early. Registration is non-transferable.

In case of withdrawal, we require written notice before September 28, 1977. An administrative fee of \$25 will be charged for any refund made.

For information and application write to:

J. Bocles, M.D., Department of
Internal Medicine
University of Miami School of Medicine
P. O. Box 520875, Miami, Florida 33152
Phone: (305) 547-6063

*Includes tuition, set of 11 textbooks, use of audiovisual aids, library loan of T.V. tapes, cassette tapes and sets, and slides.



Others Are Saying

Should You Ask Your Doctor?

Faced with unanswered health questions patients are commonly enjoined to "ask your doctor." In many instances, in fact we hope in most, the result is a correct answer based upon sound scientific data. However, even the profession itself recognizes that in a number of areas the physician may be the wrong individual to whom to inquire despite the obvious medical content of the question.

Faced with interrogation about sex, sleeplessness, diet and nutrition, for example many physicians fail to provide adequate answers simply because they have little more information than the patient. Faced with the vast and continuing problem of staying abreast with specific therapy we simply don't have time for these broad areas. They are not by their very nature easily attacked with the techniques of abstracted and abbreviated journal articles.

This leads to the present state of affairs in which these areas are populated by a significant number of non-physician specialists who ostensibly can answer questions which we can't answer. Compounding all of this is the recognized inadequacy of undergraduate and house staff education which fails to assign these subjects to any specific discipline or to any specific time.

Not the least of these "intellectual turnoffs" for the medical profession generally has been the field or discipline of diet and nutrition. It would not be an oversimplification to state that many physicians do well to know the name of a dietician to whom to make a referral so that the patient may be "instructed." Until quite recently the surest way to assure non-attendance to a post-graduate course would be to present it in this area. That patients do not see diet and nutrition in the same light is obvious from a quick perusal of almost any newspaper or magazine. A very real present demand is that we be informed about the specifics of diet and nutrition. It is quite clear that obesity, diabetes and atherosclerosis are essentially epidemic in the United States. Among the several risk factors shared by these entities is the question of the role of

diet. Not only are we concerned about the role of the generous unrestricted diet of this nation in the production of the disease, but also in the role of altered diet in the treatment.

Does a diet with decreased saturated fatty acids and cholesterol reduce the rate of morbid events? Can an aggressive approach to obesity with exercise and an appropriately constructed diet enhance both the quality and quantity of life? Certainly the intelligent prescription of a diet together with appropriate physician emphasis upon adherence is as vital as the role of insulin or cholesterol lowering oral agents.

The adequate practitioner of medicine and surgery in 1976 must have a fundamental knowledge of protein sparing fasts, jejuno-ileal by pass and hyperalimentation. Questions yet arise about dietary fiber content and colonic diverticulosis; fiber as a causal agent in cancer of the colon and the use of diet in the management of peptic ulcer and gall bladder disease. Modern obstetrical practice allows a much more liberal maternal weight gain during pregnancy to deliver a child with a higher but seemingly more ideal birth weight.

Dietary management of diabetes mellitus has shifted away from its long standing emphasis on carbohydrate stressing instead caloric prescription to achieve ideal weight. The diabetic is generally prescribed a diet with more starch and a lower content of saturated fat and cholesterol.

No physician can ignore the popularization of megadose vitamin therapy. Basic knowledge of the action of these substances, last seen in the notes of Biochemistry of the first year of medical school, is vital to the diagnosis of a radically increasing number of patients with vitamin induced or enhanced disease.

Last it is important to emphasize the simplest and cheapest of all practices — an adequate complete dietary history. Classifying this as a "lost art" assumes that it was once practiced; a matter, according to some, of considerable doubt. Such

histories reveal the appalling eating and drinking habits of the seemingly healthy adult as well as the abysmal total inadequacy of the diets of the aged dictated by economic necessity or personal preference. Careful dietary history of the hospitalized patient may well lead to the conclusion that good medical management and good dietary-nutritional management are not necessarily synonymous.

The plea then is the age old one made to medicine and physicians — we should be as able as the patients think we are! If we are to prescribe diets

we should know more than caloric values and the rudimentary fat, carbohydrate and protein content of food. To put it clearly we must "study more on these things" to effect the same level of skill in diet and nutrition prescription that we have in medical and surgical therapeutics!

Roy H. Behnke, M.D.
Tampa

Reprinted from The Editor's Column in The Bulletin of the Hillsborough County Medical Association, November, 1976.

Achilles' Heel

Various forces in Washington are jumping with glee at the thought that they have found the Achilles' heel at which to attack private medicine: rising costs.

If you recall your Homer, the heel was the one part of the body in which the Greek hero was vulnerable.

No longer can Washington accuse physicians of being 50,000 short in numbers. It cannot gainsay the peerless competence of American medicine. It cannot deny what the polls show: that most Americans are satisfied with the quality and availability of their care.

But rising costs — sensationalized by charges of Medicaid fraud on the part of a tiny minority of doctors — are being exploited as an excuse for an all-out move against our profession and its freedom.

Rate setting for medical services has been suggested by the Democratic platform and by Jimmy Carter. A move to make it mandatory in all states is likely to be made when the Health Planning Act comes up for extension in 1977 — provided that the law survives the joint suit of North Carolina and the AMA.

Yet, on the cost issue too, we physicians are generally invulnerable in fact, contrary to the thinking of some politicians.

The climb in costs is largely due to impersonal factors that far transcend the personal ability of health-care providers to control them.

These factors include the growth and expansion of clinical competence and technology, the growth of health insurance and its incentives to better care, the relentless surge in professional liability premiums. They also include greater

longevity (and thus a greater incidence of chronic illness), steady inflation, and the network of administrative and procedural expenses engendered by federal involvement in care.

Further aggravating the cost problem is the absence of any quantitative limit on what medicine is supposed to do with its technology, or expected to do. Sophisticated surgery that may stretch life by a few years is unavoidably expensive, and that expense has to be reckoned with if life is to be so stretched.

Obviously, the Topsy-like growth in the demand for, and capabilities of, medical care since World II has caused overlaps, imbalances, and disarrangements — particularly at the institutional level — and these should be relieved by voluntary planning. The AMA's blue-ribbon National Commission on the Cost of Medical Care, representing many walks of life (including government), is seeking to place the cost problem in its true perspective, so that practical remedies can be offered.

But there is no valid reason for government to try playing the role of marksman Paris and shoot an arrow at private medicine's heel.

Let us bring the real facts of medical costs to our state and communities in every way we can. The people must know that if government tries to do the worst to us, we can no longer do the best for them.

Anthony J. Vento, M.D., President
Broward County Medical Association
Fort Lauderdale

Reprinted from The President's Page of The Record, official Bulletin of the Broward County Medical Association, January 1977.



HILL CREST HOSPITAL — For Intensive Treatment of Psychiatric Disorders

This 113-bed non-governmental psychiatric hospital provides modern facilities for diagnosis and treatment of patients with all degrees of illness, including those who show severely disturbed behavior. Alcoholic and drug abuse patients are also accepted.

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MEETINGS

Approved by FMA Committee on Continuing Medical Education

JUNE

Florida Suncoast Pediatric Conference, Second Annual Meeting, June 12-15, Sheraton Sand-Key, Clearwater Beach+

Mease Hospital Tumor Board, June 16, Mease Hospital, Dunedin. For information: Paul S. Berger, M.D., 725 Virginia Street, Dunedin 33528.

Twenty Eighth Annual Scientific Assembly, June 22-26, Sandpiper Bay, Port St. Lucie. For information: Florida Academy of Family Physicians, 4057 Carmichael Avenue, Jacksonville 32207.

Post Assembly Seminar, June 26-July 3, Snow Mass, Colorado. For information: Florida Academy of Family Physicians, 4057 Carmichael Avenue, Jacksonville 32207.

JULY

The Problem of Infertility, July 11, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge, M.D., 511 W. Highland Blvd., Inverness 32650.

SEPTEMBER

Tips, Tricks, Traps and Techniques, Sept. 9-11, Sea Turtle Inn, Jacksonville Beach. For information: Duke H. Scott, M.D., 1205 Beach Boulevard, Jacksonville Beach 32250.

Colon and Rectum Cancer Conference, Sept. 10, Tampa.+

The Problem of Microscopic Hematuria, Sept. 12, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge, M.D., 511 W. Highland Blvd., Inverness 32650.

Medical Aspects of Aging, Sept. 30-Oct. 1, Gainesville Hilton, Gainesville.**

OCTOBER

Immunologic and Pharmacologic Advances in Diagnosis and Treatment of Allergic Illness, Oct. 21, Tampa.+

Scientific Assembly of Interstate Postgraduate Medical Association of North America, Oct. 31 - Nov. 3, Diplomat Hotel, Hollywood. For information: Alton Achsner, M.D., Post Office Box 1109, Madison, Wisconsin 53701.

NOVEMBER

The Problem of Glaucoma, Nov. 14, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge, M.D., 511 W. Highland Blvd., Inverness 32650.

*For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152, Tel. (305) 547-6716.

**For Information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143.

+For Information: Contact Theron A. Ebel, M.D., CME, University of South Florida Tampa 33620. Tel. (813) 974-2074.

Classified Ads

Physicians Wanted

FAMILY PRACTITIONERS

FAMILY PRACTICE: Three man clinic has opening for family practitioner. Located in central Florida, near two local hospitals. Salary first year, then partnership. Excellent opportunity. Write C-808, P.O. Box 2411, Jacksonville, Florida 32203.

MIAMI, FLORIDA: G. P. — Seven man multispecialty, fee-for-service group is seeking a G. P. to join the group. Contact Mr. Jack White, 1025 E. 25th St., Hialeah, Florida 33013. Phone: (305) 696-0842.

FAMILY PRACTICE AVAILABLE: Well established, hospital nearby, excellent location, medical records, equipment and staff available. Contact Mrs. Peggy Holland, 3144 Congress Avenue, Lake Worth, Florida 33460. Phone: (305) 965-8222.

SPECIALISTS

INTERNIST, UROLOGIST, GP'S: Outstanding opportunities in progressive nonurban community serving 20,000. Write John H. Parker, M.D., Chief of Staff, Doctors Memorial Hospital, Perry, Florida 32347.

ORTHOPEDIC SURGEON, DERMATOLOGIST. Immediate openings. Private solo practices. Liberal financial assistance including guaranteed income and free rent for first year. Attractive community, good schools. Contact Claude L. Weeks, Ex. Dir., Flagler Hospital, P.O. Box 100, St. Augustine, Florida 32084. Phone: (904) 824-8411.

WELL-ESTABLISHED SOLO INTERNIST with fully equipped 2,100 square foot, two-man office with x-ray, lab, all facilities, desires internist or other suitable physician for office sharing arrangement. Would consider cross-coverage. Write C-792, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST WITH SPECIAL INTEREST IN NONINVASIVE CARDIOLOGY. Immediate opening. Private solo practice. Financial assistance including first year free rent. Attractive community, good schools. Contact Claude L. Weeks, Executive Director, Flagler Hospital, P.O. Box 100, St. Augustine, Florida 32084. Phone: (904) 824-8411.

INTERNIST WANTED: For association with five internists. Southeast coast of Florida. Under age 35, board qualified, Florida boards not necessary. Annual salary \$35,000. Early partnership assured. Write C-797, P.O. Box 2411, Jacksonville, Florida 32203.

NEUROLOGIST NEEDED: Multispecialty clinic seeking Board Certified or Board Eligible neurologist. Attractive Gulf Coast community with excellent practice prospects. Guaranteed compensation with immediate incentive formula. All practice costs paid. Write C-802, P.O. Box 2411, Jacksonville, Florida 32203.

PEDIATRICIAN: To join 10 doctor multispecialty clinic in Winter Haven, Polk County, Florida. Salary first year, then partnership and percentage. 400-bed hospital one block. Board certified or eligible. Contact Bill Brigman, Administrator, Bond Clinic, 601 First Street North, Winter Haven, Florida 33880. Phone: (813) 293-1191.

CARDIOLOGISTS: Doctors Hospital, Jackson, Mississippi, offers an excellent opportunity with benefits for two board certified cardiologists. New Professional building to open in September, 1977. For further information contact Mr. Harold L. Burton, Administrator, (601) 982-8321 or send resume to Doctors Hospital of Jackson, 2969 University Drive, Jackson, MS 39216.

OB-GYN, INTERNIST, UROLOGIST, DERMATOLOGIST: Outstanding opportunity in Temple Terrace-Tampa Bay area.

Beautiful suburban community with several fine hospitals close by. Initial several months office rent free. Reply to C-805, P.O. Box 2411, Jacksonville, Florida 32203.

ORTHOPAEDIC SURGEON - We have an excellent opportunity for a board certified or eligible orthopaedic surgeon to join our multispecialty medical group as our second orthoped. Expanding practice requires addition to our staff. Guaranteed minimum salary 60K, incentive as full partner from day one, malpractice paid. Located 55 miles northwest of Chicago in Chain-O-Lakes resort region. Our facility is physically adjacent to a 144-bed general community hospital and State Trauma Center. Excellent support facilities. Call Jim Dickson, Personnel Director, McHenry Medical Group, 1110 North Green Street, McHenry, Illinois 60050. Phone: (815) 385-1050-Ext. 332.

OB-GYN - We are seeking a board certified or eligible physician to replace an OB partner lost because of health reasons. We are a 20 physician, multispecialty group located 55 miles northwest of Chicago in the Chain-O-Lakes resort area with easy access to the city. Our candidate will step into an active three man OB-GYN practice with incentive pay from day one (with a guaranteed minimum draw), malpractice paid, excellent fringe benefits. Our group is physically adjacent to a 144-bed general community hospital and State Trauma Center. Call or write Jim Dickson, McHenry Medical Group, 1110 North Green Street, McHenry, Illinois 60050. Phone: (815) 385-1050.

PEDIATRIC LOCUM VACANT FOR JULY 1977 - Private pediatric practice in Key West, Florida. Excellent salary and coverage arrangements. Contact S. Coira, M.D., 3245 Flagler Avenue, Key West, Florida 33040. Phone: (305) 294-5557.

MIAMI, FLORIDA AREA: Multispecialty group, fee-for-service group seeking full or part time Orthopedic Surgeon to join group. Contact Mr. Jack White, 1025 E. 25th St., Hialeah, Florida 33013. Phone: (305) 696-0842.

NEONATOLOGIST- FLORIDA GOLD COAST. Opening for board eligible pediatrician in large medical center. Extensive fringe benefits such as shared personal insurances and pension; fully paid professional insurances; four weeks vacation and continuing education leave. Contact Jack Stephens, Administrator, Broward General Medical Center, 1600 South Andrews Avenue, Fort Lauderdale, Florida 33316.

OTOLARYNGOLOGIST - Opening immediately available in a 30 man multispecialty group located in West Palm Beach for a board certified or board qualified otolaryngologist. Outstanding opportunity for the right individual to take over and head the Department of Otolaryngology. Please direct inquiries to Richard C. Hudson, M.D., Medical Director, 705 North Olive Avenue, or call direct, (305) 832-8531. Application and brochure with further information will be sent on request.

MISCELLANEOUS

ADDITIONAL PHYSICIANS URGENTLY NEEDED in rapidly growing Gulf Coast area. Most needed are internists, ENT's and pediatricians. Excellent private practice opportunity. Rural. Drawing area 40,000. 200-bed excellently equipped hospital. Excellent schools. One and one half hours from medical schools and metropolitan areas. Office space available. Send curriculum vitae to C-708, P.O. Box 2411, Jacksonville, Florida 32203.

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Mental Health Center. Florida license required. This is a CMHC with four large programs: Drug Abuse, Alcohol Counseling Center, Child Development Center and General Mental Health Program. Pensacola offers beautiful beaches and excellent recreational opportunities. No state income tax. Letters of inquiry, with resume, should be forwarded to Morris L. Eaddy, Ph.D., Executive Director, Community Mental Health Center of Escambia County, Inc., 1201 West Hernandez Street, Pensacola, Florida 32501. An equal opportunity employer.

CONFERENCES FOR MEDICAL PROFESSIONALS. A calendar listing of over 500 national/international meetings, conferences and seminars in the medical sciences for 1977. All medical specialties included. Send a \$10.00 check or money order payable to Professional Calendars, P.O. Box 40083, Washington D. C. 20016.

PHYSICIAN AND SONOGRAPHER TRAINING PROGRAM. All aspects of Diagnostic Ultrasound will be covered including how to start and operate an Ultrasound Department. One month physician program with three months and one year sonographer programs for qualified persons. Special arrangements may be considered. Limited number of applicants accepted. For further information phone or write: J. J. Crittenden, M.D., Diagnostic Ultrasound Department, West Florida Hospital and Clinic, 8383 North Davis Highway, Pensacola, Florida 32504. Phone: (904) 478-4460, Ext. 174.

FAMILY PRACTITIONER OR INTERNIST wanted to share facilities with five practitioners in solo practice. Major equipment provided. Rent \$250.00 per month. Excellent laboratory and x-ray with income based on use. Bookkeeping system shared. Financial assistance available to the right party. Contact T. C. Kenaston Jr., M.D., Box 550, Cocoa, Florida 32922.

ASPEN MUSHROOM CONFERENCE. Diagnosis and treatment of mushroom poisoning. Collection. Identification. Microscopy. Novice and advanced courses. AMA Category I. August 7-12. Hotel Jerome, Aspen, Colorado. Contact: Beth Isreal Hospital, 1601 Lowell Blvd., Denver, CO 80204. (303) 825-2190. Ext. 354.

WANTED: Physician to join several other physicians in emergency room practice in central Florida community hospital, 150 beds. Forty hour week. Benefits include 3 weeks vacation and 2 paid medical conferences. Starting salary \$40,000 yearly. Must be graduate of U.S. medical school, have AMA internship, and some previous practice desirable. Florida license necessary. Contact: James N. Kulpan, Administrator, Waterman Memorial Hospital, P.O. Drawer B, Eustis, Florida 32726. Phone: (904) 357-4161.

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PHYSICIAN WHO DESIRES MEDICAL DIRECTORSHIP of plant with 1,500 employees in north central Florida. Responsibility includes development, implementation and maintenance of total occupational health program. Affiliation with University of Florida College of Medicine encouraged. Excellent retirement and fringe benefit programs. Position open immediately. Salary negotiable. Position offers challenge. In

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Situations Wanted

INTERNIST, 32, certified in pulmonary medicine wishes to relocate. Experienced in academic hospital based patient care, licensed in Florida. Prefers West coast; will consider offers from hospitals, groups or quality internists for association. Write C-781, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST-SUBSPECIALTY ALLERGY, board certified in both, Florida license, American graduate, ten years practice experience, desires group or solo practice, Write C-767, P.O. Box 2411, Jacksonville, Florida 32203.

ORTHOPEDIC SURGEON, 30, married, university trained, available July 1978. Experienced in total joint replacement, desires partnership, group, or solo on Florida coast. American, Bilingual, Spanish-English. Write C-794, P.O. Box 2411, Jacksonville, Florida 32203.

32 YEAR OLD 3RD YEAR INTERNAL MEDICINE RESIDENT at Mayo Clinic available for locum tenens or E. R. work any part of July - mid September '77. Write C-795, P.O. Box 2411, Jacksonville, Florida 32203.

POSITION WANTED: 47, board eligible, wide experience, 8 years in anesthesia. 3 years in England. D.A. (Royal College). Licensed in Florida, available July 1977. Group or fee-for-service. Write C-796, P.O. Box 2411, Jacksonville, Florida 32203

INTERNIST BOARD CERTIFIED (1972). Florida license. Age 49. Excellent health. Wishes to relocate from large city to Florida. K. Muntz, M.D., Apt. B-15, 7625 Normandie Blvd., Cleveland, Ohio 44130.

OPHTHALMOLOGIST, 30, married, board qualified, completing fellowship in oculo-plastics; desires group or partnership opportunities; available summer 1977. Write C-799, P.O. Box 2411, Jacksonville, Florida 32203.

38 YEAR OLD BOARD CERTIFIED INTERNIST with gastroenterology subspecialty; full endoscopy training, seeks to relocate to Florida summer 1977 as soloist or with group/partnership. Write C-801, P.O. Box 2411, Jacksonville, Florida 32203.

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UROLOGIST, age 35, board eligible internal medicine; passed Part I urology boards; completing fellowship pediatric urology (1 year). Wishes association, group or partnership practice. Available July 1977. Please contact H. Kaplan, M.D., 1 Buttonwood Sq., Apt. 7g, Philadelphia, Pa. 19130. Phone: (215) 569-3634.

ORTHOPAEDIC SURGEON, board eligible, American graduate, looking for solo or group practice, available July 1977. Write C-806, P.O. Box 2411, Jacksonville, Florida 32203.

ANESTHESIOLOGIST: ABA certified, U.S. needed, University trained, 14 years experience. Desires to relocate family in South Florida. Florida license. Write or call S. N. Smock, M.D., 3050 Foxcroft, Ann Arbor, Michigan 48104. Phone: (313) 973-2584.

INTERNIST - Board eligible, seeks multispecialty group or hospital based practice. Florida license. Available now. Write C-810, P.O. Box 2411, Jacksonville, Florida 32203.

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PHYSICIAN RETIRING: TAKE OVER PRACTICE in July 1977, fast growing area of S. W. Florida. Three hospitals in area. Write C-790, P.O. Box 2411, Jacksonville, Florida 32203.

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Equipment for Sale

FOR SALE: ONE 15' BAHAMIAN SALING DINGHY — fiberglass, teakwood fittings, sail and carrying trailer, \$900; one Sajou's Encyclopedia of Medicine—a rare antique book collection; one Pelton Steam Autoclave; one Picker x-ray Unit, 300 ma, 125 pkv. 90/15 tilt table, fluoroscope, spot film device, floor to ceiling tube stand with electromagnetic locks, videx collimator, electronic bucky, 12/1 grid, one General Electric x-ray unit, 300 MA-100 VP, Full wave rectification, two tube Rad/Flu, Model KX-11, Tilt table. Contact Alex Trombly (813) 253-2667, 8:00-5:00.

FOR SALE: Ritter model B motor table with arm rest attachment. Perfect condition at a fraction of replacement cost. Contact: Dr. Lasky, 1624 Treehouse Cr., Pelican Cove, T-119, Sarasota, Florida 33581. Phone: (813) 966-5100.

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FOR SALE—FORT LAUDERDALE AREA: Real Estate practice and equipment. 3,000 sq. ft. office-2,000 sq. ft. apartment well equipped for family practice. Canal front. Write C-770, P.O. Box 2411, Jacksonville, Florida 32203.

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Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psycho-

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tropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relation-

ship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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JULY COVER — The painting on the cover entitled "Lost Children" by Mrs. James D. Moody (Magi), of Orlando, won the Editor's Award at the Auxiliary's Eleventh Annual Benefit Art Show during the FMA annual meeting, May 4-8, 1977 in Miami Beach. See article entitled "Lost Children" by J. M. Whitworth, M.D., of Jacksonville, on Page 477.



President's Page

Confidentiality

The issue of confidentiality of medical records has become a central one in the great debate going on in Washington over national health policies. This most treasured relationship, between doctor and patient, has always been held inviolate of those not privileged to be involved with them or review them, including attorneys, computers, insurance companies, federal agencies ad infinitum.

The privacy of the doctor-patient relationship is truly an endangered tradition. Through the PSRO law and other legislation, including the establishment of HSA's, with increasing federal involvement in the health care system, the government has become the greatest potential threat to the individual right to medical privacy. Through the Health Professions Education Assistance Act of 1976 (PL 94-484) private patient records of all physicians and dentists are subject to access by the regulatory provisions of the various federal agencies. The only check on these abuses, unless a greater degree of confidentiality is extended by law to private medical records, will be the goodwill of the bureaucrats. The federal bureaucracy, to say the least, is a most unreliable guarantor of our right to medical privacy.

It has also come to light that certain insurance companies and private data collecting corporations, acting as third party intermediaries between government sponsored programs and the hospital-doctor private care area, are in the process of collecting data in the name of claims processing, etc., which data then can become so-called public property, when gathered for agencies exempt under the Federal Freedom of Information Act of 1974.

Recent reports of an 18-month probe by a Federal commission have uncovered evidence that some of these companies obtain medical records of patients posing as doctors, nurses, or IRS agents, then sell this information to insurance or credit companies. Private medical information is becoming a salable, profitable black market commodity.

All of this is causing some legislators to say that privacy of medical records already is a thing of the past, and that stringent new laws must be developed, both on the national and state level, to insure the protection of private confidential medical information. The Secretary of HEW states that records concerning the names and amounts of money received by Medicare-Medicaid providers is public information. Your patient's records are next.

We have every responsibility, every obligation to resist this invasion of the very core of our relationship with our patient by getting involved in a personal and organized way in support of our efforts to legislate better public policy in this area, remembering that the confidentiality of the doctor-patient relationship is an important element in the canon of medical ethics, with intrinsic value to the practice of quality medicine.

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Please see opposite page for Brief Summary.



Chapter Two

Hollis G. Boren, M.D.

On September 15, 1976, Donn L. Smith, M.D. resigned as Founding Dean of the University of South Florida College of Medicine and began serving as Professor of Comprehensive Medicine and Pharmacology. Dean Smith's record of building a first-rate Medical Center in seven years is without parallel. This achievement was recognized at the time of full accreditation by the Association of American Medical Colleges in the statement that this Medical Center should serve as a model for other developing medical schools. The physicians of the region, the Hillsborough County Medical Association and the Florida Medical Association gave full recognition to Dean Smith's superb contribution to medical education.

Dean Smith's final contribution to this Journal, entitled, "Last Page," admirably summarized the status of the College of Medicine. Not only had Phase II of the construction of splendid physical facilities been completed and recruiting of outstanding faculty progressed satisfactorily, but also three classes of medical students had been graduated. Dean Smith has often said that we should be judged by the type of physicians that we produce. The feedback that we get from the residency programs having our graduates is "send us more like them."

What has happened since Dean Smith's resignation? What is the second chapter in the history of our Medical School? Considering that the term of office of many deans may be described as either brief or very brief, and that it is highly desirable to keep the physicians of Florida informed on the state of each of our three medical schools, please accept this introduction to Chapter Two from an Acting Dean.

We have continued on a three-year curriculum and the student body has been increased. The fourth class of 64 medical students will graduate on June 11, 1977. These graduates fared extremely well in the National Intern and Residency Matching

Program. They have performed with distinction with the majority earning honors in two or more endeavors.

A new class of 96 students will begin their medical studies on July 5, 1977. The process of sending out applications to candidates for the class next year will begin shortly thereafter. Indeed, the early decision process will be completed in August. This early decision mechanism allows the candidate for medical school to apply to one school without risk or prejudice if the candidate is not successful in competing in this manner. If successful, the candidate avoids the expense, delay, and trauma of applying to a multitude of medical schools.

The most significant addition to our curriculum is the rotation of medical students through the Ambulatory Care Center, renamed as the University of South Florida College of Medicine Medical Clinics, for better understanding by patients. The Medical Clinics consist of 60 examining rooms, five x-ray rooms, a clinical laboratory, medical records, and a business office occupying 54,000 net square feet. Noninvasive, low risk techniques such as fiberoptic examinations are used extensively. The faculty of all of the clinical departments uses this facility to teach our students how to provide health care for ambulatory patients.

Third year senior students rotate through the Medical Clinics for three months. Their educational experience compliments and extends that received in the in-patient services of our affiliated hospitals. This mode of training has the aim of teaching the student how to provide service to patients in a manner similar to that traditionally provided in private practice. The result of a balanced clinical experience both in hospitals and in the Medical Clinics is a highly competent broadly based physician. The hope is that our students will deliver primary care in a highly efficient and effective manner. The use of the new Medical Clinics as a major teaching site will then be fully realized.

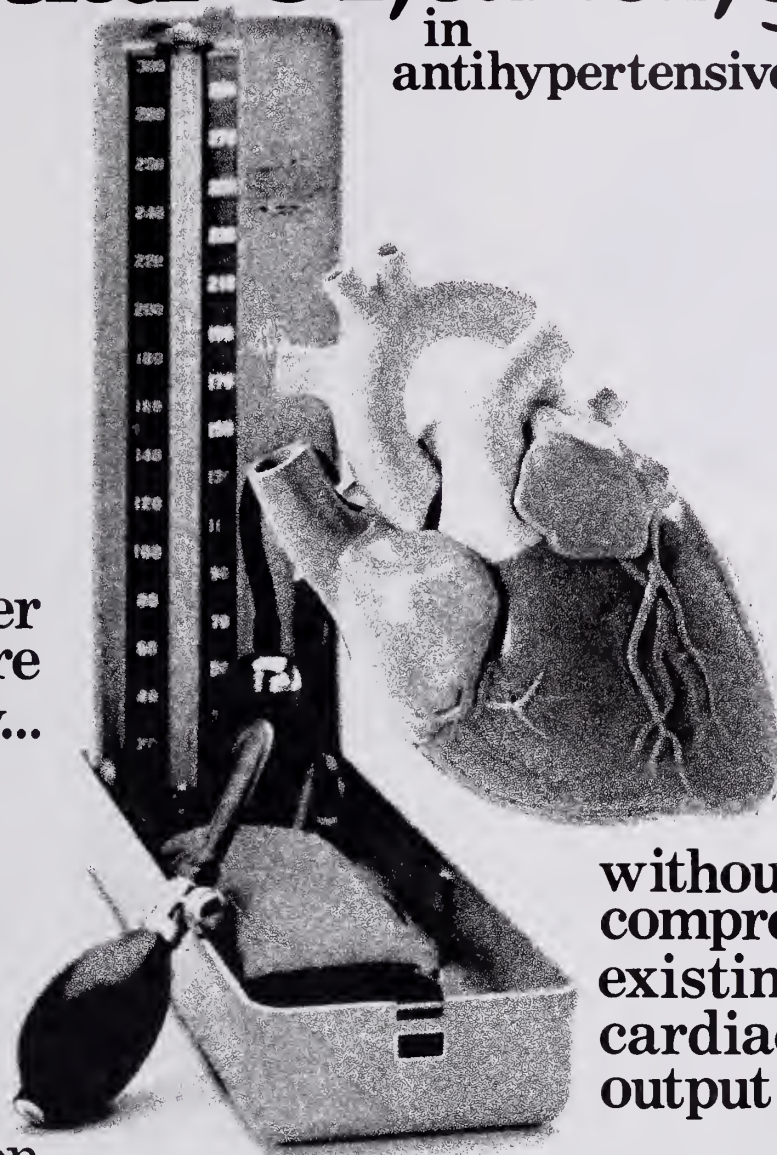
Dr. Boren is Acting Director of the Medical Center and Acting Dean of the University of South Florida College of Medicine, Tampa.

- Dr. Boren, University of South Florida, 12901 North 30th Street, Tampa.

A Dual Challenge

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to lower
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TABLETS: 250 mg, 500 mg, and 125 mg

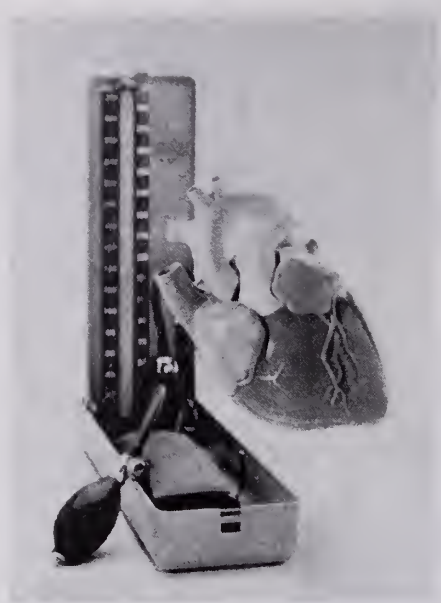
ALDOMET[®] (METHYLDOPA | MSD)

helps lower blood pressure effectively...
usually with no direct effect on
cardiac function—cardiac output
is usually maintained

ALDOMET is contraindicated in active hepatic disease, hypersensitivity to the drug, and if previous methyldopa therapy has been associated with liver disorders. It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

For a brief summary of prescribing information, please see following page.

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in hypertension

ALDOMET®

(METHYLDOPA|MSD)

helps lower
blood pressure
effectively...
usually with no
direct effect on
cardiac function—
cardiac output is
usually maintained

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis; if previous methyl dopa therapy has been associated with liver disorders (see Warnings); hypersensitivity.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyl dopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyl dopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyl dopa. If a positive Coombs test develops during methyl dopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyl dopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyl dopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyl dopa, the drug should not be reinstituted. When methyl dopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyl dopa is stopped.

Should the need for transfusion arise in a patient receiving methyl dopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or

cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyl dopa. If caused by methyl dopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyl dopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Use in Pregnancy: Use of any drug in women who are or may become pregnant requires that anticipated benefits be weighed against possible risks; possibility of fetal injury can not be excluded.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyl dopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyl dopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyl dopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patients on methyl dopa because the drug is removed by this procedure.

Adverse Reactions: Central nervous system: Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decreased mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease daily dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyl dopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatus, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia. Leukopenia, granulocytopenia, thrombocytopenia.

Allergic: Drug-related fever, myocarditis.

Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, dermatologic reactions including eczema and lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited to 500 mg daily when given with antihypertensives other than thiazides. Tolerance may occur, usually between second and third month of therapy; increased dosage or adding a thiazide frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Syncope in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

How Supplied: Tablets, containing 125 mg methyl dopa each, in bottles of 100; Tablets, containing 250 mg methyl dopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyl dopa each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

JEAM07 (707)

MSD MERCK SHARP & DOHME

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OF THE

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DONALD C. JONES, Executive Director

June 30, 1977

SUMMARY OF FMA BOARD OF GOVERNORS MEETING

JUNE 26, 1977

The following is a summary of the actions taken by the Board of Governors at its meeting on June 26, 1977. The Board:

FMA PRIORITIES Adopted the following priorities for the 1977-78 Association year.

MEMBERSHIP

Continue and intensify the informational program for county medical societies and the membership

Continue and strengthen all aspects of Continuing Medical Education Program and accelerate accreditation activities

Improve liaison and coordination with county medical society officers and staffs, and specialty groups

PUBLIC

Continue to implement the FMA Medical Services Program with special emphasis on emergency medical services.

Careful analysis and implementation of a program dealing with the cost of medical care to include continued study and implementation of programs to assist in containing the rapid increase in the cost of medical care including evaluation and appropriate action of proposed cost containment legislation

PROGRAMS

Further implementation of FMA Public Relations program for members and the general public

Place more emphasis on depth and grass roots support for legislative activities

Implement a political educational program and an active committee in each community

Careful study and liaison with the Florida Constitutional Revision Commission

Careful analysis and input into governmental programs, such as Public Law 93-641, National Health Planning and Development Act with special emphasis on HSA's, and the State Health Coordinating Council and its Committees

Implementation of a statewide PRO

Establishment of a statewide health data system under the auspices of the private sector through the Florida Health Data Corporation

Continued review and efforts to update third party fee schedules, specifically the Workmen's Compensation Medical and Surgical fee schedule, and the Department of HRS Medical Fee Schedule

Continue efforts through the Florida Medical Foundation to promulgate a Peer Medical Utilization Review program for Florida's Medicaid Program

ISSUES

National Health Insurance

Professional Liability Legislation (Recovery of Defense Costs)

Separate Department of Health with Cabinet rank

MANAGEMENT

Review of the FMA Executive staff and organization

Branch offices in south and central Florida

Special review of finance accounts and consultants

CALLED MEETING, HOUSE OF DELEGATES

Reviewed the FMA Called Meeting of the House of Delegates which was called at the request of three county medical societies; Seminole, Orange and Osceola. The President, in accordance with the Bylaws of the Florida Medical Association, called a meeting of the House of Delegates to be held Sunday, June 12, 1977, at the Holiday Inn Airport, Tampa, Florida.

There were 101 delegates and 28 county medical societies represented which did not constitute a quorum; therefore, the House of Delegates could take no official action. The following motion was agreed to by those present:

"That those present have declared themselves the unofficial caucus of members of FMA to discuss National Health Insurance, and

"That the Speaker is Charles J. Kahn, M.D., and

"That this group hereby requests the FMA Board of Governors conduct a mail poll of members to reconsider the FMA's position on support of the AMA sponsored bill for National Health Insurance."

FMA BYLAWS AMENDMENTS

Recommended to the House of Delegates that the FMA Bylaws be changed to require for a Called Meeting of the House of Delegates, a written request from 10% or more of the current delegates and 10% or more of the current chartered component societies and that the request be ratified by mail by at least a majority of the current delegates at least five days prior to the designated hour of convening of such Called Meeting.

FMA MEMBERSHIP POLL

Directed that an appropriate poll be conducted of the FMA membership regarding the AMA's National Health Insurance legislative proposal.

1978 MEETING DATES

Adopted the following schedule of meeting dates for FMA during 1978 and noted the AMA meeting dates:

Executive Committee — January 13, 1978

Board of Governors — January 14-15, 1978

AMA Leadership Conference — January 26-29, 1978

Interim or Called Meeting, House of Delegates — February 3-5, 1978

Executive Committee — March 17, 1978

Board of Governors — March 18-19, 1978

FMA Annual Meeting — Diplomat — May 3-7, 1978

Executive Committee — June 3, 1978

Board of Governors — June 4, 1978

AMA Annual Meeting — St. Louis, Mo. — June 17-22, 1978

Executive Committee — October 4, 1978

Board of Governors — October 5-7, 1978

AMA Interim Session — Chicago, Ill. — December 2-6, 1978

AMA Winter Scientific Session — Las Vegas — December 7-10, 1978

HOUSE OF DELEGATES RATIO

Approved the current ratio of one delegate to each forty active members used in determining the total composition of the House of Delegates for the 1978 annual meeting. (No change this year.)

PRE-TRIAL MEDICAL MEDIATION PANEL PROCEDURES

Approved the petition of the Florida Supreme Court to amend the proposed rules of the Florida medical mediation procedures on behalf of the FMA as prepared by FMA Legal Counsel.

H.S.A.'S

Approved the establishment of a special statewide committee of the FMA on Health Systems Agencies to perform in a modified similar fashion to that program of the Minnesota State Medical Association and directed appropriate staff be assigned by the Executive Vice President.

EMERGENCY MEDICAL SERVICES

Authorized FMA representatives to pursue negotiating a federal contract to perform emergency medical services in Florida which are currently being performed by the state of Florida through the Florida Medical Foundation.

DEFENSE FUND

Received as information an updated report on FMA assistance to physicians for countersuits (currently 10 in number) and, in particular, the successful suit of John B. Sullivan, M.D., who was awarded \$175,000 and settled for the reduced amount of \$75,000 as set by the trial judge.

1977 LEGISLATIVE SESSION

Reviewed in detail the FMA Legislative Program during the 1977 Session of the Florida Legislature and commended those individuals directly concerned with its success.

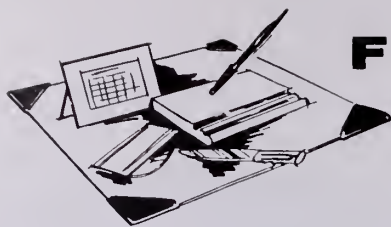
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FROM THE EDITOR'S DESK

CALIFANO APOLOGIZES

HEW Secretary Joseph Califano has apologized to AMA for the error-riddled list of Medicare physicians his agency put out on March 12. "I am deeply distressed at the number of errors," Califano wrote AMA Executive Vice President James H. Sammons, M.D., "and I regret any embarrassment that may have been caused to any of your members." AMA found a 65% error rate in HEW's listing of physicians who supposedly received \$100,000 or more each in Medicare payments in 1975.

* * * *

TALMADGE BILL

Sen. Herman Talmadge of Georgia has introduced a redrafted version of legislation allowing HEW to halt disclosure of Medicare payments to physicians. He said the disclosure provision of S. 1770 "simply would avoid an unfair appearance of guilt on the part of physicians who may be rendering significant amounts of necessary services to Medicare patients at reasonable charges."

* * * *

SECOND OPINION

AMA has told Congress that second opinions are not necessarily a valid method of determining the medical necessity of surgical procedures. AMA Executive Vice President James H. Sammons, M.D., testified before the House Commerce Subcommittee on Oversight and Investigations. He said a second opinion "is just that and nothing more—an opinion which is, by definition, subjective." Dr. Sammons said it looks as if the Subcommittee wants to establish criteria for determining when surgery would be elective under Medicare and Medicaid.

FLORIDIANS APPOINTED

Max Michael, Jr., M.D., of Jacksonville, has been named Chairman of the AMA Advisory Committee on Graduate Medical Education. Mrs. C. H. Gilliland of Gainesville is the AMA Auxiliary Representative to the AMA Council on Scientific Affairs.

* * * *

PSRO SUPPORT

AMA has asked the Department of HEW to continue statewide PSRO support in those states that request it and can benefit from it. HEW had announced plans to disband the nine existing state support centers by September 30.

* * * *

MORE MONEY

Congressional leaders have been urged to increase funding for several health programs. AMA said it favored increasing President Carter's budget proposals for the National Institutes of Health, health professions education, maternal and child health, family planning, National Health Service Corps, emergency medical service, immunization, venereal disease, lead based paint poisoning prevention, occupational health, mental health, alcoholism, programs for older Americans, Food and Drug Administration, and the Indian Health Service.

* * * *

LAETRILE

The Food and Drug Administration has branded as hearsay evidence of the efficacy of the cancer drug laetrile. "No worthless drug is without harm," FDA said in a bulletin to physicians and hospital administrators.

AGE DISCRIMINATION

A model bill to prohibit age discrimination in employment has been approved by the AMA Board of Trustees for distribution to state medical societies. The Board also approved a draft bill to amend Medicare to allow reimbursement to the physician for services provided by his physician extender.

* * * *

LAETRILE

Proponents of the controversial substance laetrile, promoted as an anti-cancer agent, have made additional inroads to have the product legalized. A new Oklahoma law permits doctors and hospitals to administer laetrile to cancer patients who request it. A Delaware statute permits laetrile to be manufactured and sold in the State. Legislatures of Florida, Arizona, Alaska, Indiana, Nevada, Texas, Washington and Louisiana previously passed laetrile bills.

* * * *

ACCREDITATION

The Federal Trade Commission is persisting in its efforts to have the Liaison Committee on Medical Education ousted as the accrediting agency for medical schools. FTC's Bureau of Competition asked the Commissioner of Education "to take a personal interest" in the matter. FTC said it is concerned that LCME "an organization tied to and heavily influenced by the American Medical Association, has sole authority over the accreditation of United States medical schools — and hence over the supply of physicians." The Office of Education's Advisory Committee has recommended a two-year extension for LCME.

* * * *

RECERTIFICATION

The American Board of Pediatrics and the American Academy of Pediatrics have announced a voluntary program for continuing education and assessment leading to board recertification. The Academy will develop educational programs, publish a journal on continuing education, sponsor courses and approve self-assessment exercises. The Board will be responsible for the recertification process. The program will begin in 1979.

RVS

The Minnesota State Medical Association and 34 of its county societies have signed a Federal Trade Commission consent order barring the use of relative value scales. Not admitting to any violation of law, MSMA said its relative value index "has been used as a means of coding and defining medical procedures for third party payors in both the public and private sectors." It denied an FTC contention that the index, introduced in 1963 and updated four years ago, contributes to higher medical costs.

* * * *

INDEX MEDICUS

The Government Printing Office Bookstore in Jacksonville is stocking the 1975 and 1976 editions (Vols. 16 and 17) of **Cumulated Index Medicus** for sale at \$192 and \$202, respectively. Information may be obtained by contacting the Bookstore, P.O. Box 35089, Jacksonville 32202, telephone: (904) 791-3801.

* * * *

ASSISTANT HEW SECRETARY

Julius B. Richmond, M.D., has been named Assistant HEW Secretary for Health. Dr. Richmond is head of the Department of Preventive and Social Medicine at Harvard and was Vice Chairman of the AMA Council on Mental Health in 1969.

* * * *

FOREIGN MEDICAL GRADUATES

AMA has urged Congress to modify proposed amendments to the Immigration and Nationality Act that would require alien physicians before entering the country to pass Parts I and II of the National Boards (or its equivalent) and prove competency in written and oral English. In a statement to a House Judiciary subcommittee, AMA said it is concerned that the bill could result in "a substantial reduction in the number of foreign medical graduates in accredited residency programs in the U.S. on July 1, 1977," and "could lead to a serious dislocation of medical services, particularly in metropolitan public hospitals."

The Editor

Multiple Choice

Check one. Which do you think is the best use for ENSURE® Liquid Nutrition?

- ☐ A. **SUPPLEMENTAL FEEDINGS . . .** ENSURE tastes good. Available in patient-pleasing Vanilla and Black Walnut flavors, plus five VARI-FLAVORS™ FLAVOR PACS, ENSURE is an ideal selection for supplemental feedings.
- ☐ B. **FULL LIQUID DIETS . . .** Orally or by gavage tube, ENSURE provides complete, balanced nutrition with ample carbohydrate and fat to spare protein for tissue synthesis.
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- ☒ D. **ALL OF THE ABOVE . . .** Right! Why? That's as simple as A, B, C. Next time one of your patients needs liquid nutrition, choose ENSURE, the multi-purpose liquid food designed for use in a variety of feeding situations.



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*Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.
Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.

Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

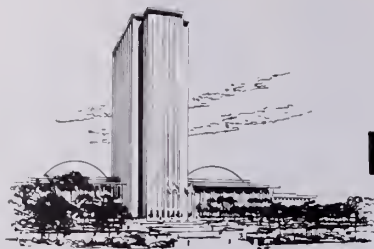
Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

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Mead Johnson LABORATORIES



LEGISLATIVE NEWS

Most observers feel that the 1977 Legislative Session was a most successful one from the standpoint of medicine. Not only was the Association successful in getting reenactment of the 1976 medical malpractice tort reforms, but all legislation which was opposed was defeated.

While the individual accomplishments are of course noteworthy, the overall success demonstrated the vitality and effectiveness of the key contact physician program. During the past session, many legislators made contact with the Capital Office asking how they could help with the Association's legislative objectives, because of the excellent prior-session briefings given to them by their contact physicians. The very fine work done by the key contact physicians and county society executives built a strong core of "friends" at the beginning of the session, thus allowing the staff and consultants to concentrate on a few "questionable" votes to insure success.

In addition to the reenactment of the 1976 medical malpractice tort reforms, the principal legislative proposals supported by the Association which passed were:

1. Revision of Florida's emergency medical services act to include certification of paramedics and advanced life support equipment. This bill requires paramedics to be under the general supervision of a physician. (SB-1011)
2. Legislation to require standardized health claim forms for all insurers in the State and the Department of HRS. (SB-6)
3. Provision in both the House and the Senate Appropriations Act allowing the Department of HRS to contract with private medical foundations for PMUR for Medicaid. (This, of course, must be reaffirmed during the special session.)

Several items of legislation of principal concern to Florida physicians, which would have had

adverse effects on the quality or costs of delivery of medical care in Florida, were successfully opposed by the Association. These items were.

1. Requirement for a certificate of need on selected items of equipment in a physician's office (CAT scanners, radiation therapy equipment, and cardiac catheterization labs). Supporting the bill, in opposition to the FMA, were not only the Department of HRS and the Governor's Office, but the Florida Association of Life and Casualty Insurers, the Florida Council of 100, and Blue Cross. It is interesting to note that while a great deal of emphasis was placed on trying to bring under the certificate of need regulation physicians' office equipment, proponents paid little attention to the provisions which would allow construction of private hospitals in Florida under existing grandfather clauses. This will add significantly more to Florida's health care costs than so-called "abuses" of private providers. (HB-2236)
2. Restriction of supervision and staffing of geriatric nurse outpatient clinics to advanced nurse practitioners. This legislation was amended to allow these facilities to be staffed and managed by, not only advanced nurse practitioners, but RNs and physicians' assistants.
3. Licensure of radiologic technologists. This legislation would have required any person using x-ray equipment, even under a physician's supervision, to be licensed as a radiologic technologist. Not only would the measure have increased costs, but there is a possibility that there is a lack of trained personnel at the present time in Florida who could meet the requirements of legislation. (HB-689, SB-591)
4. Requirement that all professional and occupational boards have a consumer as a member. (HB-1028, SB-1428)
5. Provisions to restrict physicians' reimbursement under Florida's Workmen's Compensation laws. The Senate version of the

Workmen's Compensation law revision included language which would have allowed the Department of Commerce to establish a fee schedule for physician reimbursement without relating the level of payment to a prevailing charges in the same or similar medical community (as is the present law). This was defeated in the House Commerce Committee and not included in the final version of the legislation.(SB-1082)

6. Provision in the automobile insurance law to establish a system of "company doctors." The Senate version of the automobile no-fault revision contained a provision that would have required companies to offer a discounted policy, provided the purchaser agreed to use only physicians and other providers approved and selected by the insurance company.

7. Truth in sickness legislation. This legislation would have required extensive reporting by physicians who have ownership in any health care facility or pharmaceutical company. It also required physicians having such ownership to not only make the annual reports to the Department of HRS, but to

give patients referred to such facilities a disclosure of the ownership interest. (HB-1941, SB-1142)

8. Licensure of individual practitioners who perform acupuncture. This bill not only would have required physicians using acupuncture to have a special license, but would have allowed chiropractors to use acupuncture assistants to administer this procedure. The net result of this, many feared, would have been to greatly expand chiropractic acupuncture clinics throughout the state. (HB-2313)

9. Tax on physicians to subsidize practice in areas of need. This legislation would have placed a \$100 tax on out-of-state physicians, and an additional \$10 fee on in-state physicians, to subsidize salaries for medical practitioners working in rural or urban areas of need. Under the bill, physicians would have been subsidized up to a level of \$60,000. The Association has been actively working to develop mechanisms to assist placement of physicians in rural areas, and pointed out to Committee members that while income is one factor in location, it is not generally the deciding one. (SB-1198, SB-530)

Clinical Laboratory Licensure Exam Is Announced

The next clinical laboratory personnel state licensure written examinations will be given in October.

The Department of Health and Rehabilitative Services announced that directors, supervisors and technologists will be examined on Wednesday, October 19. The technicians' examination will be on October 20.

Applications must be received in the Office of Laboratory Services, Department of Health and Rehabilitative Services, P. O. Box 210, Jacksonville 32201 by August 26, 1977.

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announce

The Fourth Annual Cardiovascular Symposium

September 22-23, 1977

THE HILTON INN

GAINESVILLE, FLORIDA

Director: Howard W. Ramsey, M.D.
Co-Directors: Luis J. Cintado, M.D.
Thomas D. Bartley, M.D.

The symposium is designed to present advances and to review and explore diagnostic and therapeutic approaches for the detection and treatment of cardiovascular disease. An outstanding faculty has been selected for this symposium and the program should be of interest to all physicians involved in the care of patients with cardiovascular problems.

FACULTY

Agustin Castellanos, M.D.
Larry Elliott, M.D.
Ray Gifford, M.D.
John Kirklin, M.D.
Dean Mason, M.D.
William Roberts, M.D.

Kenneth Cooper, M.D.
Thomas B. Ferguson, M.D.
J. Willis Hurst, M.D.
John Laragh, M.D.
Dennis Pupello, M.D.
Donald Ross, M.D.

Charles Dotter, M.D.
Peter Gazes, M.D.
Spencer King III, M.D.
George Lindesmith, M.D.
Ramiro Rivera, M.D.

(Approval for continuing education credits has been requested from the FAFP, FMA, AACN, FNA, NFLPN's and the Florida Board of Pharmacy.)

HOTEL RESERVATIONS: A block of rooms has been reserved at the Hilton Inn for symposium participants and reservations can be made through your local Hilton Inn, the Hilton Reservation Service (toll free number listed in your local telephone directory) or by calling the Gainesville Hilton Inn directly (904) 377-4000.

RESERVATION FEES: \$175. — all physicians
50. — paramedical personnel (nurses, technicians, etc.)

MAKE CHECKS PAYABLE TO: FOURTH ANNUAL CARDIOVASCULAR SYMPOSIUM

MAIL TO: Howard W. Ramsey, M.D.
Program Director
North Florida Regional Hospital
P.O. Box 13494
Gainesville, Florida

REGISTRATION IS LIMITED — REGISTER EARLY

(Fees will be refunded on cancellations received before 8/26)
For further information, contact Howard W. Ramsey, M.D. (address above)

When Griseofulvin is indicated...



TINEA PEDIS*



TINEA UNGUIUM*



TINEA CRURIS*



TINEA CAPITIS*

*Also *Tinea barbae* and *Tinea corporis* when caused by fungi from genera known to be sensitive to griseofulvin.

Gris-PEG[®] (griseofulvin ultramicrosize) Tablets 125 mg offers effective therapy with 1/2 the dose.[†]

- Can be taken on an empty stomach
- Absorption nearly complete without fatty meals
- Reduced cost for patients
- Once-a-day or b.i.d. dosage

[†]250 mg of Gris-PEG[®] provides plasma levels equivalent to those obtained with 500 mg microsize griseofulvin. This improved absorption permits the oral intake of half as much griseofulvin but there is no evidence, at this time, that this confers any significant clinical difference in regard to safety or efficacy.



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Gris-PEG[®]

(griseofulvin ultramicrosize) Tablets
125 mg

The ½ dose griseofulvin.

DESCRIPTION

Griseofulvin is an antibiotic derived from a species of *Penicillium*.

Gris-PEG is an ultramicrocrystalline solid-state dispersion of griseofulvin in polyethylene glycol 6000.

Gris-PEG Tablets differ from griseofulvin (microsize) tablets USP in that each tablet contains 125 mg of ultramicrosize griseofulvin biologically equivalent to 250 mg of microsize griseofulvin.

ACTION

Microbiology: Griseofulvin is fungistatic with *in vitro* activity against various species of *Microsporum*, *Epidermophyton* and *Trichophyton*. It has no effect on bacteria or other genera of fungi.

Human Pharmacology: The peak plasma level found in fasting adults given 0.25 g of Gris-PEG occurs at about four hours and ranges between 0.37 to 1.6 mcg/ml.

Comparable studies with microsize griseofulvin indicated that the peak plasma level found in fasting adults given 0.5 g occurs at about four hours and ranges between 0.44 to 1.2 mcg/ml.

Thus, the efficiency of gastrointestinal absorption of the ultramicrocrystalline formulation of Gris-PEG is approximately twice that of conventional microsize griseofulvin. This factor permits the oral intake of half as much griseofulvin per tablet but there is no evidence, at this time, that this confers any significant clinical differences in regard to safety and efficacy.

Griseofulvin is deposited in the keratin precursor cells and has a greater affinity for diseased tissue. The drug is tightly bound to the new keratin which becomes highly resistant to fungal invasions.

INDICATIONS

Gris-PEG (griseofulvin ultramicrosize) is indicated for the treatment of the following ringworm infections:

Tinea corporis (ringworm of the body)
Tinea pedis (athlete's foot)
Tinea cruris (ringworm of the thigh)
Tinea barbae (barber's itch)
Tinea capitis (ringworm of the scalp)
Tinea unguium (onychomycosis, ringworm of the nails)

when caused by one or more of the following genera of fungi:

Trichophyton rubrum
Trichophyton tonsurans
Trichophyton mentagrophytes
Trichophyton interdigitalis
Trichophyton verrucosum
Trichophyton megnini
Trichophyton gallinae
Trichophyton crateriform
Trichophyton sulphureum
Trichophyton schoenleinii
Microsporum audouinii

Microsporum canis
Microsporum gypseum
Epidermophyton floccosum

NOTE: Prior to therapy, the type of fungi responsible for the infection should be identified.

The use of the drug is not justified in minor or trivial infections which will respond to topical agents alone.

Griseofulvin is *NOT* effective in the following

Bacterial infections
Candidiasis (Moniliasis)
Histoplasmosis
Actinomycosis
Sporotrichosis
Chromoblastomycosis
Coccidioidomycosis
North American Blastomycosis
Cryptococcosis (Torulosis)
Tinea versicolor
Nocardiosis

CONTRAINDICATIONS

This drug is contraindicated in patients with porphyria, hepatocellular failure, and in individuals with a history of sensitivity to griseofulvin.

WARNINGS

Prophylactic Usage: Safety and Efficacy of Griseofulvin for Prophylaxis of Fungal Infections Has Not Been Established.

Animal Toxicology: Chronic feeding of griseofulvin, at levels ranging from 0.5 to 2.5% of the diet, resulted in the development of liver tumors in several strains of mice, particularly in males. Smaller particle sizes result in an enhanced effect. Lower oral dosage levels have not been tested. Subcutaneous administration of relatively small doses of griseofulvin, once a week, during the first three weeks of life has also been reported to induce hepatomata in mice. Although studies in other animal species have not yielded evidence of tumorigenicity, these studies were not of adequate design to form a basis for conclusions in this regard.

In subacute toxicity studies, orally administered griseofulvin produced hepatocellular necrosis in mice, but this has not been seen in other species. Disturbances in porphyrin metabolism have been reported in griseofulvin treated laboratory animals. Griseofulvin has been reported to have a colchicine-like effect on mitosis and cocarcinogenicity with methylcholanthrene in cutaneous tumor induction in laboratory animals.

Usage in Pregnancy: The safety of this drug during pregnancy has not been established.

Animal Reproduction Studies: It has been reported in the literature that griseofulvin was found to be embryotoxic and teratogenic on oral ad-

ministration to pregnant rats. Pups with abnormalities have been reported in the litters of a few bitches treated with griseofulvin. Additional animal reproduction studies are in progress. Suppression of spermatogenesis has been reported to occur in rats, but investigation in man failed to confirm this.

PRECAUTIONS

Patients on prolonged therapy with any potent medication should be under close observation. Periodic monitoring of organ system function, including renal, hepatic and hematopoietic, should be done.

Since griseofulvin is derived from species of *Penicillium*, the possibility of cross sensitivity with penicillin exists; however, known penicillin-sensitive patients have been treated without difficulty.

Since a photosensitivity reaction is occasionally associated with griseofulvin therapy, patients should be warned to avoid exposure to intense natural or artificial sunlight. Should a photosensitivity reaction occur, lupus erythematosus may be aggravated.

Griseofulvin decreases the activity of warfarin-type anticoagulants so that patients receiving these drugs concomitantly may require dosage adjustment of the anticoagulant during and after griseofulvin therapy.

Barbiturates usually depress griseofulvin activity and concomitant administration may require a dosage adjustment of the antifungal agent.

ADVERSE REACTIONS

When adverse reactions occur, they are most commonly of the hypersensitivity type such as skin rashes, urticaria, and rarely, angioneurotic edema, and may necessitate withdrawal of therapy and appropriate countermeasures. Paresthesias of the hands and feet have been reported rarely after extended therapy. Other side effects reported occasionally are oral thrush, nausea, vomiting, epigastric distress, diarrhea, headache, fatigue, dizziness, insomnia, mental confusion, and impairment of performance of routine activities.

Proteinuria and leukopenia have been reported rarely. Administration of the drug should be discontinued if granulocytopenia occurs.

When rare, serious reactions occur with griseofulvin, they are usually associated with high dosages, long periods of therapy, or both.

DOSAGE AND ADMINISTRATION

Accurate diagnosis of the infecting organism is essential. Identification should be made either by direct microscopic examination of a mounting of infected tissue in a solution of potas-

sium hydroxide or by a culture on an appropriate medium.

Medication must be continued until the infecting organism is completely eradicated as indicated by appropriate clinical or laboratory examination. Representative treatment periods are—*tinea capitis*, 4 to 6 weeks; *tinea corporis*, 2 to 4 weeks; *tinea pedis*, 4 to 8 weeks; *tinea unguium*—depending on rate of growth—fingernails, at least 4 months; toenails, at least 6 months.

General measures in regard to hygiene should be observed to control sources of infection or reinfection. Concomitant use of appropriate topical agents is usually required particularly in treatment of *tinea pedis*. In some forms of athlete's foot, yeasts and bacteria may be involved as well as fungi. Griseofulvin will not eradicate the bacterial or monilial infection.

An oral dose of 250 mg of Gris-PEG (griseofulvin ultramicrosize) is biologically equivalent to 500 mg of griseofulvin (microsize) USP (see ACTION Human Pharmacology).

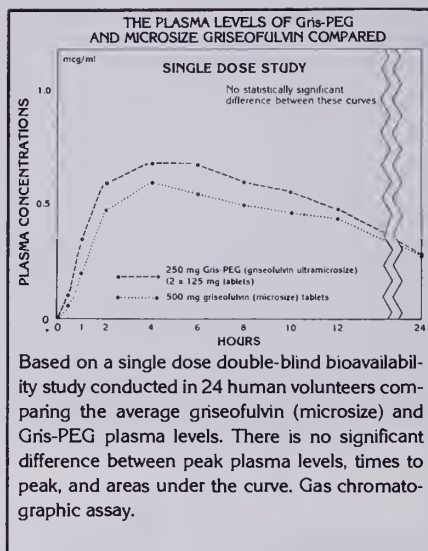
Adults: A daily dose of 250 mg will give a satisfactory response in most patients with *tinea corporis*, *tinea cruris* and *tinea pedis*. One 125 mg tablet twice per day or two 125 mg tablets once per day is the usual dosage. For those fungal infections more difficult to eradicate such as *tinea pedis* and *tinea unguium*, a divided daily dose of 500 mg is recommended. In all cases, the dosage should be individualized.

Children: Approximately 5 mg per kilogram (2.5 mg per pound) of body weight per day is an effective dose for most children. On this basis the following dosage schedule for children is suggested: Children weighing over 25 kilograms (approximately 50 pounds) 125 mg to 250 mg daily; children weighing 15-25 kilograms (approximately 30 to 50 pounds) 62.5 mg to 125 mg daily; children 2 years of age and younger, dosage has not been established.

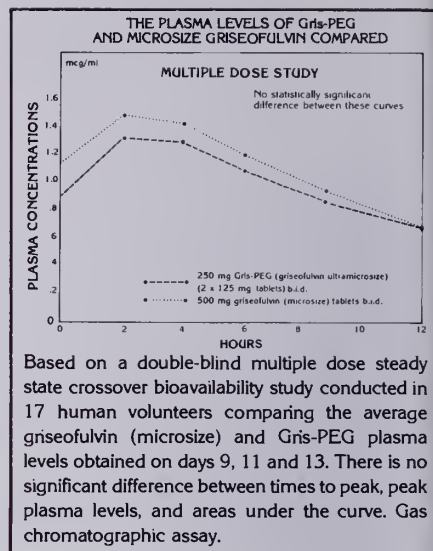
Dosage should be individualized, as is done for adults. Clinical experience with griseofulvin in children with *tinea capitis* indicates that a single daily dose is effective. Clinical relapse will occur if the medication is not continued until the infecting organism is eradicated.

HOW SUPPLIED

Gris-PEG (griseofulvin ultramicrosize) Tablets (white) differ from griseofulvin microsize tablets (USP) in that each tablet contains 125 mg of ultramicrosize griseofulvin, biologically equivalent to 250 mg of microsize griseofulvin. Two 125 mg tablets of Gris-PEG are biologically equivalent to 500 mg of microsize griseofulvin. In bottles of 100 and 500 scored, film-coated tablets.



Based on a single dose double-blind bioavailability study conducted in 24 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels. There is no significant difference between peak plasma levels, times to peak, and areas under the curve. Gas chromatographic assay.



Based on a double-blind multiple dose steady state crossover bioavailability study conducted in 17 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels obtained on days 9, 11 and 13. There is no significant difference between times to peak, peak plasma levels, and areas under the curve. Gas chromatographic assay.

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PROCEEDINGS

One Hundred Third Annual Meeting — Florida Medical Association, Inc.

Bal Harbour, May 4-8, 1977

PRESIDENT'S ADDRESS

PROGRESS

Jack A. MaCris, M.D.

When Barry Goldwater was running for President, some of his critics suggested that the basis for his defense policy was first to arrange the wagons in a circle. Some of the critics of our profession view us in a similar light. This is in part due to the fact that we do not run to embrace every half-baked scheme regarding medical matters that emanates from Washington.

Every active organization expects to make progress toward its goals each year, and the Florida Medical Association, being an active organization, is no different in this regard. Last June, shortly after

the Annual Meeting, the Executive Committee met to outline the priorities of activity for the coming year as it has in the past, and as it will again a month from now. At the called meeting of the House of Delegates in January, we presented update reports on our activities, and these reports indicated that we had made progress. It was while preparing these reports that I began to dwell a bit on what constituted progress.

For an organization such as ours we have first our overall long-range goals of achievement which basically endure and continue, and second, our short-range action-type goals aimed primarily at achieving our overall objectives. Both must be reviewed periodically, and in context with one another, if we are to make progress. It would be easy indeed to focus down on some short-range objective so intently as to lose sight of our primary purpose for existing. To begin our discussion, I would like to read Article II of our Charter, which clearly states our aims and is the ultimate base line by which we judge our progress. "The general nature of the objects of the corporation is to promote the science and art of medicine, and the betterment of public health; to unite the medical profession of Florida into one compact organization, and to federate with similar organizations in other states and territories to form the American Medical Association, to extend medical knowledge and to advance medical science; to elevate the standards of medical



President Jack A. MaCris, M.D. addresses the House of Delegates.

education; to strive for the enactment, preservation, and enforcement of just medical and public health laws; to promote friendly relationships among physicians, and to guard and foster their material interests; to enlighten and alert the public; to encourage similar interests and objectives in the corporation's component medical societies, and to carry out these objects of the corporation as a business league not organized for profit, and no part of the net earnings shall inure to the benefit of any private member or individual."

The most overworked criticism of organized medicine is its resistance to change. The inference, of course, is that change is progress. Unfortunately, many equate the two, whereas often the opposite is true. There are many examples in society's history. When the Athenian democracy was flourishing, a change was instituted allowing representatives to be selected to sit in the senate as substitutes for the freeholders. This relieved the freeholders of the burdens of running the government, and soon the government was in Rome. Change, but hardly progress.

And closer at home, the United States became convinced following World War II that it was time to change its economic philosophy from that of trying to achieve a balanced budget to one of deficit spending, and we now have a devalued dollar on the world market to show for it. Again, change but hardly progress.

One of the highlights of this year for me personally was the opportunity to visit England, both for the purpose of meeting our representatives to the Lloyds of London, and at the same time to join the AMA tour of the British National Health Service. This afforded us an inside look at the system after almost 30 years of its existence, and I would like to take an extra few moments here to tell you of some of our experiences, and comment upon the system since it is in keeping with our subject. Here was England, a modern country not afraid to make a major change in her approach to the health care needs of her people. And here was a system often touted as the prototype of ideal health care for all of Europe and the United States. We were able to visit emergency rooms, hospital wards, and research laboratories, and discuss the national health system with a broad spectrum of those people involved in it. We talked with bureaucrats who administered the programs, to doctors caring for the patients, to hospital administrators in charge of the hospitals, as well as the English people themselves as patients. The single most interesting thing to me was to find

that despite the dire economic plight of the system, and for that matter of England herself, almost everyone in and out of the system rose to the defense of the national health system when speaking to us as outsiders. This despite the lack of funds to improve their facilities, or build new beds, or purchase new equipment, as well as lengthening lines of patients waiting for elective operations. As we toured the halls of St. Bartholomew's Hospital in downtown London, I saw the cockroach and rat pellets in the corners of the Emergency Rooms and listened as the doctor in charge of the Emergency Room explained with pride the portable monitor and resuscitative equipment which could be loaded into an ambulance for an emergency call, at the same time admitting that should another similar emergency arrive at the front door while the equipment is in the ambulance there would be a slight delay until the equipment could be returned. I could not help but compare this almost obsolete equipment to our well equipped emergency room and ambulances at home. I visited the Recovery Room, the Thoracic Surgical Intensive Care Unit, which was not air conditioned, and looked out the open, unscreened windows into the courtyard below, unconsciously comparing the recent modern additions to Bellevue, and Grady, and Charity Hospitals. Was this 30 years of progress?

Another interesting sidelight that same day was the visit to the internationally known endocrine research laboratory housed in the basement of old Barts. This appeared to be flourishing, and we later learned that its success was in part due to an infusion of money by one of the American drug companies interested in endocrine related products. The company was being hampered in its research in the United States by the Food and Drug Administration. This was, indeed, a change and difficult to evaluate as progress.

During the long flight home from London, I relived our experiences and realized that overall it had been a depressing visit into the health care system of England. Again I thought, a change, but not one that I could classify as progress. In fact, after the overall accounting was done, I would consider it a blight rather than a boon to progress in the health care of the people of Britain.

Now, if a blight strikes a farmer's crop, and he is successful in eliminating the blight, he feels he has made progress although the end result is only to preserve what he has initially. In this light, our successful opposition to changes detrimental to our present system is a similar progress, and I believe

we are obligated to constantly monitor and oppose similar health schemes being proposed in this country.

Conversely, when a good idea for change appears, Florida medicine has been enthusiastic in embracing it. The Blue Shield program here in Florida is a good example. Doctors of Florida invested their own money, time, and effort to initiate a concept to provide good medical care for the people of Florida in all economic levels.

This was progress in a giant step. Most progress occurs in smaller increments, and as a continual building process adding a little bit to the accomplishments of our predecessors as we go along our way. Our legislative activity is a good example of this. We have matured over the years, gaining experience and being stimulated to a more rapid pace these last few years by Medicare, Medicaid, and our liability insurance crisis. Our new building in Tallahassee, our increased budget, and professional help have made our voice in Tallahassee better heard.

And our FMA spring visitations to Washington, D.C. each year has improved communications with our national legislators. This trip consists of the officers of the Association and the key contact physicians of each national legislator visiting each of these men in their offices in the Capitol to discuss with them legislation related to medical matters. This not only acquaints our legislators with our opinions, but also educates us regarding the legislative process, and opens up avenues of communications with the legislative aides in Washington who are well informed and anxious to help. As an aside, I stood at the window of my hotel room the evening I arrived, and looked across the way to the White House brightly lighted up, and our flag flying behind it, and behind the flag the tall spire of the Washington Monument. It was an inspiring sight. The next morning as I walked past the Capitol Building, a male high school chorus on spring break from school was lined up on the steps singing, "God bless America." These experiences do rekindle the spirit.

Therefore, as we review our situation I submit that the Florida Medical Association is alive and well. It is receptive to change when such change improves and advances its stated goals as set forth in its charter. Our voluntary adoption of our continuing medical education program, the

establishment of a self-insurance reciprocal, and an active public relations program to begin to more effectively bring our story to the people of Florida, are good examples. These are not the results of an organization characterized by negative, unimaginative thinking, but rather by a progressive, energetic, enthusiastic attitude, unafraid of the risk of change, but tempered by the judgment of maturity and experience. This is change that is true progress.

Progress implies that there is more to follow. Then what confronts us in the future? We are currently struggling with some unsolved problems, such as the rising costs of health care, and the best way to provide care for the medically indigent, or those rendered indigent by virtue of a devastating accident or protracted illness. And perhaps somewhat more distant, but no less important, are the moral and ethical problems we will be facing as we read about scientists in the laboratory changing cell structure, and in fact synthesizing a living cell. Will they create in time a Superman or Frankenstein, and should they create either one?

I am confident Florida medicine will face these problems head-on with the same maturity of judgment and innovative thinking that has characterized it in the past.

As I come to the close of my year in office, I would like to thank each of you in the House of Delegates who have given time and thought on behalf of the Florida Medical Association. Also, each of you who have served on committees and councils, and lastly and mostly to those men on the Board of Governors who have had to wrestle with the final decisions which determine our course forward. Also, I would like to thank Harold Parham and Don Jones and the FMA Staff - and I would like to thank and compliment Jackie Harrison and the Auxiliary who put a little light in my life. And finally, I would like to thank you all for permitting me the stewardship of our organization this past year. It has been a rich and rewarding experience, and I thank you for it. I am indebted to my predecessors for their numerous accomplishments which helped pave my way. This is well described by a quotation from the philosopher, Bernard of Chartres, "We are like dwarfs, seated on the shoulders of giants. If we see more and further than they, it is not due to our own clear eyes or tall bodies, but because we are raised on high and upborne by their gigantic bigness."

All progress has resulted from people who took unpopular positions.—Adlai Stevenson

General Session

The General Session of the 103rd Annual Meeting of the Florida Medical Association was called to order at 11:00 a.m. on Friday, May 6, 1977, in the Medallion Room of the Americana Hotel, Bal Harbour, Florida, by the President, Jack A. MaCris, M.D.

Dr. MaCris introduced persons seated at the head table, then announced the winners of the scientific exhibit awards.

1977 Scientific Exhibit Awards

FIRST PLACE: "Thoracoscopy in Children" - Bradley M. Rodgers, M.D., Alvin H. Felman, M.D., James L. Talbert, M.D., William H. Donnelly, M.D. Eva Hvizdala, M.D., and Richard A. Murbach, M.D., Gainesville.

SECOND PLACE: "Combining Ultrasound and Nuclear Scanning for Diagnosis of Hepato-Biliary Disease" - N. Henry Pevsner, M.D., Aldo N. Serafini, M.D., W. R. Janowitz, M.D., W. M. Smoak III, M.D., and Noel R. Zusmer, M.D., Hialeah.

THIRD PLACE: "Telescoping Hip Screw - Its Use and Abuse" - Merlin G. Anderson, M.D., Gilberto Vega, M.D., and Robert Yamokowski, M.D., Veterans Administration Hospital and University of South Florida College of Medicine, Tampa.

HONORABLE MENTION FOR TECHNICAL EXCELLENCE: "Hearing Loss: Newer Methods of Evaluation and Treatment" - Fredric W. Pullen II, M.D., Lennon G. Adams, M.S., and Constance Cabeza, M.A., Miami.

Mrs. Jackie Harrison, President of the FMA Auxiliary, presented checks representing AMA-ERF contributions in the amounts of \$5,223.89 for the University of Miami School of Medicine; \$8,388.99 for the University of Florida College of Medicine; \$4,672.66 for the University of South Florida College of Medicine; and \$1,952.21 for the Florida State University Program in Medical Sciences. Acting Dean William B. Deal, M.D., of the University of Florida, accepted all the checks on behalf of the other deans who were not present.

Dr. MaCris introduced Mr. William F. Buckley Jr., nationally known columnist and commentator, who presented the annual Baldwin Lecture.

Discussing "Some of the Problems of Freedom," Mr. Buckley stressed the necessity of maintaining a free market place, an action he contended would subsequently preserve individual freedoms.

In the first of three propositions on the problems of freedom, Mr. Buckley stated that "the freedom to deceive is over indulged," and that the assumed watchdogs of our freedom have ignored the deception. In particular he pointed an accusing



Columnist-commentator William F. Buckley Jr., of New York City, presents the annual Baldwin Lecture.

finger at the intellectual class which he claimed is leading the public to "serfdom" through deception.

Ralph Nader, termed a social hero by Mr. Buckley, was accused of being "obsessed with the number of cornflakes missing from a package," while failing to address the fact that the typical politician of the left expounds speeches lacking "middles."

In the second point of his remarks, Mr. Buckley said, "The alleged intellectual inferiority of the class of practicing American capitalists is less critical a factor in bringing them into the disesteem of the public than their ambiguous moral performance."

In regard to this point, Mr. Buckley noted that workers in the United States and Russia have an alliance without Marxism, but that capitalists and communists have a stronger kinship. "The entrepreneurial class in America can change its image only by taking a wholesome joy from its achievements and by seeing human freedom whole, or not at all," he said.

Thirdly, Mr. Buckley postulated, "Freedom, as far as much of the public is generally aware, is a condition describable only by highly subjective postulations."

Dr. MaCris adjourned the meeting at 12:25 p.m.

First House of Delegates

The First House of Delegates convened at 4:30 p.m. on Wednesday, May 4, 1977, in the Bal Masque Room of the Americana Hotel, Bal Harbour, Florida, with Charles J. Kahn, M.D., Speaker of the House, presiding.

The invocation was given by William J. Dean, M.D., Past President.

Dr. John Carlson, Chairman of the Credentials Committee, reported that a quorum of 191 delegates were present and that enough counties were represented to constitute a quorum. Dr. Carlson moved that the delegates be seated. The motion carried.

Delegates

ALACHUA—O. Frank Agee, M.D.; Mark V. Barrow, M.D.; Thomas D. Bartley, M.D.; Daniel B. Cox, M.D.; William B. Deal, M.D.; D. O. Jenkins, M.D.; William W. Pfaff, M.D.; Gerold L. Schiebler, M.D.; James C. Campbell, Jr., Student)

BAY—John F. Mason, Jr., M.D.; Clark A. Whitehorn, M.D.

BREVARD—Harold F. Albert, M.D.; William J. Broussard, M.D.; James E. Carter, M.D.; Michael J. Foley, M.D.; Laudie E. McHenry, M.D.; Burton Podnos, M.D.

BROWARD—Miles J. Bielek, M.D.; Robert J. Brennan, M.D.; Andre S. Capi, M.D.; Burns A. Dobbins, M.D.; Arthur Eberly, M.D.; John M. Harper, M.D.; George P. Messenger, M.D.; Ray E. Murphy, Jr., M.D.; Franklin B. Ott, M.D.; Thomas F. Regan, M.D.; Peter A. Tomasello, M.D.; Juan S. A. Wester, M.D.; James C. Woulfe, M.D.; (Absent - Charles H. Bechert, II, M.D.; Bruce B. Burgess, M.D.; Russell B. Carson, M.D.; Milton P. Caster, M.D.; Willis N. Dickens, M.D.; Joseph

E. Gelety, M.D.; Gary Gieseke, M.D.; David C. Lane, M.D.; Raymond E. Parks, M.D.; James P. Perry, M.D.; Joseph M. Sachs, M.D.; Diran M. Seropian, M.D.; Anthony J. Vento, M.D.)

CAPITAL—Robert P. Johnson, M.D.; Nelson H. Kraeft, M.D.; George N. Lewis, M.D.; Jack W. MacDonald, M.D.; Robert N. Webster, M.D.

CHARLOTTE—(Absent - Melvyn J. Katzen, M.D.; Fred P. Swing, M.D.)

CITRUS—HERNANDO—W. Randall Jenkins, M.D.; (Absent - William R. Lay, M.D.)

CLAY—Laurin G. Smith, M.D.

COLLIER—Fred A. Butler, M.D.; Edwin E. Dean, M.D.; Nicholas H. Kalvin, M.D.

COLUMBIA—(Absent - Barney E. McRae, M.D.)

DADE—Edward R. Annis, M.D.; Jose S. Bocles, M.D.; Rufus K. Broadway, M.D.; Richard C. Clay, M.D.; Jack Q. Cleveland, M.D.; Vincent Corso, M.D.; O. William Davenport, M.D.; Joseph H. Davis, M.D.; Charles A. Dunn, M.D.; Augusto Fernandez-Conde, M.D.; L. Marshall Goldstein, M.D.; Norman Gottlieb, M.D.; Julian H. Groff, M.D.; Leo Grossman, M.D.; Marshall F. Hall, M.D.; Joseph Harris, M.D.; Walter C. Jones, II, M.D.; Norman M. Kenyon, M.D.; Warren Lindau, M.D.; Charles A. Monnin, Jr., M.D.; Joseph T. Ostroski, M.D.; Jorge R. Pena, M.D.; Raul V. Rivet-Arambula, M.D.; Oscar S. Sandoval, M.D.; Janice K. Sherwood, M.D.; Everett Shocket, M.D.; Samuel P. Stokley, M.D.; Chauncey M. Stone, M.D.; William M. Straight, M.D.; Charles F. Tate, M.D.; John C. Turner, M.D.; Edgar W. Webb, M.D.; Sheldon Zane, M.D.; (Absent - Emilio Alderguia, M.D.; Hilario Anido, M.D.; Manuel L. Carbonell, M.D.; Sol Center, M.D.; Eduardo E. Delgado, M.D.; Isaac Egozi, M.D.; Ivor Fix, M.D.; Richard M. Fleming, M.D.; Eugene Flipse, M.D.; Raul E. Galliano, M.D.; Richard L. Glatzer, M.D.; Stephen H. Glucroft, M.D.; Pedro



FMA officers follow along as John A. Rush, M.D., Jacksonville (standing left) presents the report of Reference Committee IV. Upper dais: Past President Vernon B. Astler, M.D.; Vice President O. William Davenport, M.D.; President-Elect Louis C. Murray, M.D.; Vice Speaker Sanford A. Mullen, M.D. (presiding); Speaker Charles J. Kahn, M.D.; Executive Vice President W. Harold Parham, D.H.A.; President Jack A. MacCris, M.D.; Treasurer Richard S. Hodes, M.D.; and Secretary Robert E. Windom, M.D. Other members of Reference Committee IV are seated on lower dais.

FIRST HOUSE OF DELEGATES

- J. Greer, M.D.; Abraham Gurinsky, M.D.; Henry C. Hardin, M.D.; James R. Jude, M.D.; Herbert S. Kaiser, M.D.; Robert B. Katims, M.D.; Banning G. Lary, M.D.; Maurice H. Laszlo, M.D.; Milton E. Lesser, M.D.; Carlos G. Llanes, M.D.; Rose E. London, M.D.; Thomas J. Noto, M.D.; Victor A. Politano, M.D.; Pedro A. Ramos, M.D.; Arvey I. Rogers, M.D.; Walter M. Sackett, M.D.; Philip Samet, M.D.; Edward W. St. Mary, M.D.; Mario Stone, M.D.; Shreve M. Archer, Student)
- DESOTO-HARDEE-GLADES—Calvin W. Martin, M.D.
- DUVAL—James L. Borland, M.D.; William P. Booras, M.D.; Yank D. Coble, M.D.; Wilbert L. Dawkins, M.D.; Charles P. Hayes, Jr., M.D.; H. Joseph Hurlburt, M.D.; Walter C. Jarrell, M.D.; John C. Kruse, M.D.; Charles B. McIntosh, M.D.; Faris S. Monsour, M.D.; Daniel B. Nunn, M.D.; John A. Rush, M.D.; Guy T. Selander, M.D.; Robert H. Threlkel, M.D.; William D. Walklett, M.D.; (Absent - Samuel J. Alford, Jr., M.D.; Warren M. Barrett, M.D.; J. Robert Benson, M.D.)
- ESCAMBIA—George L. Carr, M.D.; Eric F. Geiger, M.D.; Theodore J. Marshall, M.D.; Charles F. McConnell, M.D.; (Absent - John H. Whitcomb, M.D.; Henry M. Yonge, M.D.)
- FRANKLIN-GULF—Joseph P. Hendrix, M.D.
- HIGHLANDS—Glenn V. Hough, M.D.; (Absent - Donald C. Hartwell, M.D.)
- HILLSBOROUGH—Francis C. Coleman, M.D.; Robert J. Courtney, M.D.; Irving M. Essrig, M.D.; John C. Fletcher, M.D.; J. Carlisle Hewitt, M.D.; Richard S. Hodes, M.D.; Victor H. Knight, Jr., M.D.; Thomas E. McKell, M.D.; John K. Petrakis, M.D.; Ralph M. Stephan, M.D.; William W. Trice, M.D.; Harold L. Williamson, M.D.; (Absent - Richard G. Connar, M.D.; Joel W. Mattison, M.D.; William Mahon Myers, M.D.; Woody N. York, M.D.)
- INDIAN RIVER—(Absent - Donald L. Ames, M.D.; Ferdinand F. Becker, M.D.)
- LAKE—Fred C. Andrews, M.D.; Thomas D. Weaver, M.D.; (Absent - Ernest Wollin, M.D.)
- LEE—Larry P. Garrett, M.D.; H. Quillian Jones, Jr., M.D.; Marcus M. Moore, M.D.; (Absent - John S. Hagen, M.D.; Francis L. Howington, M.D.)
- MADISON—(Absent - Julian M. Durant, M.D.)
- MANATEE—Anthony Cuva, M.D.; Robert King, M.D.; John D. Lehman, M.D.; Roger A. Meyer, M.D.
- MARION—C. Brooks Henderson, M.D.; Samuel L. Renfroe, M.D.
- MARTIN—Richard Q. Penick, M.D.; John F. Powers, M.D.
- MONROE—Ronald H. Chase, M.D.; J. Lancelot Lester, Jr., M.D.
- NASSAU—Jose Luis Castillo, M.D.
- OKALOOSA—William W. Thompson, M.D.; Eugene R. Valentine, M.D.
- ORANGE—Clarence C. Bailey, M.D.; Manuel J. Coto, M.D.; Sam F. Elder, M.D.; Clarence M. Gilbert, M.D.; Allen K. Holcomb, M.D.; Rufus M. Holloway, M.D.; Donald V. Jablonski, M.D.; G. Brock Magruder, M.D.; Franklin B. McKechnie, M.D.; James F. Richards, Jr., M.D.; James J. Schoeck, M.D.; Edward W. Stoner, M.D.; T. Byron Thames, M.D.; Robert B. Trumbo, M.D.; (Absent - Edward L. Farrar, M.D.)
- OSCEOLA—George Albert Gant, M.D.
- PALM BEACH—Vernon B. Astler, M.D.; John D. Corbitt, Jr., M.D.; Jerry F. Cox, M.D.; James Russell Forlaw, M.D.; Luis Guerrero, M.D.; Bernard Kimmel, M.D.; Doris E. Lake, M.D.; Charles E. Metzger, M.D.; Richard Benjamin Moore, M.D.; Thomas E. Murphy, M.D.; Reginald J. Stambaugh, M.D.; Arthur L. Trask, M.D.; Dick L. Van Eldik, M.D.; Harold A. Yount, M.D.
- PANHANDLE—Herbert E. Brooks, M.D.; (Absent - William F. Brunner, M.D.)
- PASCO—Nessan McCann, M.D.; (Absent - Morris L. Saperstein, M.D.)
- PINELLAS—Emil Eddy Burns, M.D.; Thomas M. Daniel, M.D.; Charles K. Donegan, M.D.; John M. Hamilton, M.D.; Kay Knight Hanley, M.D.; Daniel S. Hellman, M.D.; David S. Hubbell, M.D.; Morris J. LeVine, M.D.; Jack A. MaCris, M.D.; William F. Mallette, M.D.; James Hugh Miller, M.D.; Donald G. Nikolaus, M.D.; David T. Overbey, M.D.; Walter H. Winchester, M.D.; (Absent - Walter W. Hamilton, M.D.; James M. Neill, M.D.)
- POLK—Thomas M. Caswall, M.D.; Clyde E. Gibson, M.D.; John W. Glotfelty, M.D.; Robert B. Peddy, M.D.; C. Russell Smith, M.D.; Paul A. Tanner, Jr., M.D.; Luther A. Youngs, III, M.D.; Frank Zeller, Jr., M.D.
- PUTNAM—(Absent - Roy E. Campbell, M.D.)
- ST. JOHNS—William W. O'Connell, M.D.; (Absent - James J. DeVito, M.D.)
- ST. LUCIE-OKEECHOBEE—Howard C. McDermid, M.D.; William H. Meyer, Jr., M.D.
- SANTA ROSA—(Absent - William N. Watson, M.D.)
- SARASOTA—John N. Carlson, M.D.; Kenneth C. Kiehl, M.D.; Douglas R. Murphy, M.D.; Franklin Pfeifferberger, M.D.; Richard C. Rehmyer, M.D.; Karl R. Rolls, M.D.
- SEMINOLE—Luis M. Perez, M.D.; Maria P. Perez, M.D.
- SUWANNEE-HAMILTON-LAFAYETTE—(Absent - Laurent V. Radkins, M.D.)
- TAYLOR—John H. Parker, M.D.
- VOLUSIA—Richard W. Snodgrass, M.D.; (Absent - Octavius B. Bonner, M.D.; Richard L. Dillard, M.D.; Michael H. Fronstin, M.D.; Irwin Leider, M.D.; James G. White, M.D.)
- WALTON—(Absent - Howard F. Currie, M.D.)
- SPEAKER OF THE HOUSE—Charles J. Kahn, M.D.
- VICE SPEAKER—Sanford A. Mullen, M.D.

Information for Delegates

The Rules and Order of Business for the House of Delegates is included in this Handbook.

Delegates and alternates whose names appear in this Handbook have been certified by the county medical societies. Our By-Laws do not permit an alternate to serve for a delegate who has once been seated. The By-Laws require that delegates fill out attendance cards at **each meeting** of the House of Delegates in order to be credited in attendance, and further, the chairman of the Credentials Committee is required to report to the House the number of delegates who have registered their attendance cards, thus eliminating the necessity of a roll call to seat delegates.

Reports and resolutions that were received before going to press are included in this Handbook. Delegates are urged to study them carefully before they are introduced in the House. Wherever possible, it is requested that resolutions and supplemental reports be forwarded to the Association's executive office by April 27 for duplication and distribution to the delegates.

All reports and resolutions will be referred to Reference Committees by the Speaker at the First Meeting of the House of Delegates. All members who are interested in any committee report or resolution should attend the Reference Committee meetings where a full discussion will take place. Council and committee chairmen are respectfully requested to be present and discuss their respective reports. All members of Reference Committees are urged to study carefully the reports and resolutions referred to them. The chief purpose of the Reference

FIRST HOUSE OF DELEGATES

Committees is to allow an opportunity for as many members of the Florida Medical Association as possible to appear and be heard and thus have a voice in the business of the Association. In addition, discussions before the Reference Committees have the added advantage of avoiding long discussions at the meetings of the House of Delegates. Members may request the Reference Committee chairman to defer items in which they are interested in order that they may be present to discuss the subject.

A resolution before the Reference Committee **must have a sponsor present** before the Reference Committee. All resolutions must be filed by 12:00 noon on the day of the First Meeting of the House of Delegates, typewritten and in proper form. The resolutions so presented will be duplicated and available by the time the First House convenes. Only the "Resolved" portion of resolutions will be adopted as policy. Your attention is called to the format of the annual meeting, where the Reference Committee meetings will be held in the morning following the First Meeting of the House.

All Reference Committee reports will be duplicated and available to the delegates at the Registration Desk on Saturday morning. We trust these provisions will result in an efficient and informed House of Delegates.

All reports and resolutions included in this Handbook, as well as those which will be in the Delegates' Packets and the reports of the Reference Committees, have been printed on colored paper for easy reference. This color code is as follows:

- Reference Committee No. I — Green
- Reference Committee NO. II — Buff
- Reference Committee No. III — Blue
- Reference Committee No. IV — Pink
- Reference Committee No. V — Goldenrod

According to our By-Laws, nominations and seconding speeches shall be limited to a maximum of two minutes each. If additional information needs to be presented, it should be duplicated and distributed to members of the House.

Your Speaker and Vice Speaker are available at any time to help in any way in the preparation of resolutions or in any capacity in which they might help any member of the Florida Medical Association.

Charles J. Kahn, Speaker
House of Delegates
Sanford A. Mullen, Vice Speaker
House of Delegates

A motion carried to adopt the minutes of the 1976 House of Delegates, as published in the July 1976 issue of the Journal of the Florida Medical Association.

A motion carried to adopt the minutes of the Called Meeting held January 28-30, 1977, as published in the March 1977 Journal of the Florida Medical Association.

Dr. Kahn, Speaker, advised that during the past year a number of FMA members departed this life and that among these was a past president, Edward Jelks, M.D. In memory of these physicians roses had been placed in the vases at each end of the Speaker's podium. Dr. Kahn asked the House to observe a moment of silent prayer out of respect and memory of these doctors who have passed on.

The Speaker introduced the officers of the Association: Drs. Sanford A. Mullen, Vice-Speaker; Jack A. MaCris, President; Louis C. Murray, President-Elect; Vernon B. Astler, Immediate Past President; O. William Davenport, Vice President; Robert E. Windom, Secretary; Richard S. Hodes, Treasurer; and W. Harold Parham, Executive Vice-President.

The Speaker then instructed the House.

Remarks of the Speaker

President MaCris, Officers of the Florida Medical Association, Fellow Delegates, and Honored Guests, it is my privilege to welcome you to the 103rd Annual Meeting of the House of Delegates of the Florida Medical Association. I would also like to thank you for your willingness to give of your time and your knowledge to your Association.

The detailed instructions to delegates have been published in your handbook. I shall not elaborate on them at this time. The Vice Speaker and I will be available to assist you with any questions you might have. Please do not hesitate to call on us.

Your respective county societies have honored you by placing in you their trust to earnestly represent them at this meeting. Let me urge you to enter into every facet of the deliberations here this week. Your opinions are vital. Without them the decisions which may be reached here may well be lacking in validity. There is no way for everyone to agree on each and every final decision; however, there is a mechanism by which every opinion will and shall be heard. Each opinion has value of its own and adds to the importance of any actions taken here. Your handbook contains much vital information which has been gleaned throughout the year, and discussed by the various councils and committees of your Association, study it carefully. If you have questions concerning any committee or council report, I would suggest to you that you seek out the chairman or a member of that committee or council and put your questions to him. I am sure that he will be more than happy to answer them.

The Speaker and Vice-Speaker will attempt to conduct this meeting in a fair and expedient manner. There shall be no one who so wishes who shall not be heard from this floor. I ask your indulgence and patience for any seeming oversight. I assure you it shall not be intentional.

I would like to thank you for the opportunity to again stand on this honored podium. I hope that I may conduct the affairs of this House in as efficient and honorable manner as my many illustrious predecessors have.

Thank you again for being here and may God bless each of you whom I am proud to call my colleagues. Thank you.

The remarks of the Speaker of the House of Delegates were referred to Reference Committee No. III for consideration.

Dr. Kahn introduced Mr. Jack W. Herbert, President, Blue Shield of Florida, Jacksonville; E. Charlton Prather, M.D., Director, Division of Health, Tallahassee; Mrs. R. Benjamin Moore, President-Elect, Florida Medical Association Auxiliary; Mrs. William H. Harrison, President, Florida Medical

Association Auxiliary; Jere W. Annis, M.D., Lakeland, AMA Board of Trustees; Francis T. Holland, M.D., Tallahassee, Vice President, American Medical Association; and Mrs. L. W. Hewit, President of Southern Medical Association.

Mrs. Harrison was invited to make a few remarks.

Mrs. Harrison summarized the accomplishments of the Auxiliary during the past year. She stated that special emphasis had been placed on promoting better health and health education and better relations between physicians and physicians' families. Mrs. Harrison thanked the FMA and each of the physicians and also the volunteers. She presented Dr. MaCris with a diploma stating that he had graduated from our ranks as leader.

Dr. Holland was invited to make a few remarks. Dr. Holland recounted some of the highlights of his 22 years as an FMA Delegate to the AMA. He stated that he thought that AMA delegates and alternates should be elected at some time other than the end of the meeting, and that the Executive Committee and the delegates should work more closely together, especially on resolutions to be submitted to the AMA. He noted that delegates should be notified immediately of any names submitted to AMA for councils and committees so that the delegation might give better support of Florida candidates. He gave a brief description of the current activities of the AMA and its position on National Health-

Insurance. He concluded by thanking the house for the privilege of serving as a delegate for 22 years.

Dr. Kahn requested Dr. John Carlson and Dr. Robert E. Windom to escort Dr. Edward F. Rushton, Sarasota, to the podium to receive the A. H. Robins Company Award for "Outstanding Community Service by a Physician."

A. H. Robins Company Award "For Outstanding Community Service By A Physician"

F. Edwards Rushton, M.D., of Sarasota, who has dedicated his professional and personal life to helping ill, disadvantaged and crippled children both through civic activities and the faithful practice of pediatric medicine, has been elected to receive the 1977 A. H. Robins Company Award for Outstanding Community Service by a Florida Physician.

Each year, the Board of Governors faces the difficult task of singling out a member of the Florida Medical Association for this honor from nominees proposed from FMA's county medical societies. Recipients are selected on the basis of services rendered to their communities.

A mere glance at the long list of Dr. Rushton's activities and accomplishments leaves no doubt that he has given generously of himself to his profession and to the improvement and social well-being of his adopted home of Florida.

Francis Edwards Rushton was born in Birmingham, Alabama, 49 years ago, but moved to New Hampshire early in his life. He was graduated from Phillips Exeter Academy, Exeter, New Hampshire, in 1946. He graduated from Washington and Lee University with a B.A. degree in history in 1950. In 1957, he received his M.D. degree followed by an internship and Assistant



President Jack A. MaCris, M.D., St. Petersburg, presents special awards to F. Edwards Rushton, M.D., Sarasota (left); State Sen. Thomas M. Gallen, Bradenton (center); and Mr. Arthur W. Saarinen, Ft. Lauderdale (right). Dr. Rushton was the recipient of the A. H. Robins Company Award for Outstanding Community Service by a Physician. Senator Gallen was the recipient of the Distinguished Layman Award. Mr. Saarinen, a Broward County banker, received a Certificate of Grateful Appreciation for his 25 years of service on the Board of Directors of Blue Shield of Florida.

FIRST HOUSE OF DELEGATES

Residency in pediatrics at the University of Michigan at Ann Arbor. A Post-Doctoral Fellowship in Arthritis at the Rackham Arthritis Institute of the University of Michigan and service as Senior Resident in Pediatrics at the University of Michigan followed before Dr. Rushton moved to Florida.

He became Chief Resident and Instructor in the Department of Pediatrics at the University of Florida in Gainesville, before entering private practice in Sarasota in 1961. In September of 1970, Dr. Rushton became the full-time Chief of the Bureau of Crippled Children of the State of Florida in Tallahassee and served as the Acting Chief from March 1971 until June of 1972, during which time he had also returned to private practice in Sarasota.

Dr. Rushton has served as Associate Instructor of Pediatrics at the University of Florida and continues to serve as Associate Professor of Pediatrics in the Department of Pediatrics at the University of Florida, a position he also held at one time at the University of Miami. He holds hospital privileges at Sarasota Memorial Hospital and Shands Teaching Hospital of the University of Florida, Gainesville.

Dr. Rushton is a member of the Sarasota County Medical Society as well as the Florida Medical Association, the American Medical Association, the Florida Pediatric Society, the American Academy of Pediatrics, the Sarasota Pediatric Society and is Chapter Chairman of the Florida Chapter of the American Academy of Pediatricians.

In the field of civic activities, Dr. Rushton has concentrated most of his efforts in the area of care for children. He is Director of Children and Youth Health Services of the Sarasota County Health Department and is Chairman of the Task Force for Children in the Florida Heart Association. He is also a member of the American Heart Association Committee of Insurability of Children with Congenital Heart Disease and the University of Florida College of Medicine Committee on the Feasibility of a Children's Hospital.

Other civic activities include the Sarasota Memorial Hospital Intensive Care Committee, the Suncoast Heart Association Community Service Committee, the Sarasota Branch of the Suncoast Heart Association Board of Directors, the Department of Health and Rehabilitation Services Task Force on Rheumatic Fever, and membership in the Kiwanis Club.

In 1969, Dr. Rushton was presented the Sertoma Club's Service to Mankind Award. The presentation commemorated Dr. Rushton's efforts to provide quality health care in a practical way to children of migrant laborers. By identifying the problem, Dr. Rushton developed evening medical centers for needy children so parents would not have to pay double for health care by taking time off from work and paying a medical fee. After migrant workers left the Sarasota area in 1968, the service continued to be needed by permanent residents and was maintained.

Dr. Rushton expressed his appreciation for the award and noted special thanks to his county medical society.

Dr. Kahn introduced the President, Dr. Jack A. MaCris, to deliver his address to the House. Before delivering his address, Dr. MaCris introduced his wife, Janet.

The President's Address was referred to Reference Committee No. III.

The Speaker assumed the chair and announced the members of the Reference Committees, the

assignment of AMA Delegates to the Reference Committees and that the Meetings of the Reference Committees would all begin at 10:00 a.m.

No. 1 — Health and Education

Charles Tate, M.D., Chairman
William B. Deal, M.D.
Clarence Gilbert, M.D.
Paul Tanner, M.D.
James Jude, M.D.

No. 2 — Public Policy

Calvin Martin, M.D., Chairman
Michael J. Foley, M.D.
Janice Sherwood, M.D.
John C. Kruse, M.D.
Franklin Pfieffenberger, M.D.

No. 3 — Finance and Administration

Robert Johnson, M.D., Chairman
Joseph Harris, M.D.
Franklin McKechnie, M.D.
Kay Hanley, M.D.
Harold Yount, M.D.

No. 4 — Legislation and Miscellaneous

John Rush, M.D., Chairman
George P. Messenger, M.D.
Herbert Brooks, M.D.
John Hamilton, M.D.
Richard Clay, M.D.

No. 5 — Medical Economics

Frank Coleman, M.D., Chairman
Warren Lindau, M.D.
Fenner McConnel, M.D.
John Parker, M.D.
Andre Capi, M.D.



Vernon B. Astler, M.D., Boynton Beach, Immediate Past President of the Association, and Baldwin Lecturer William F. Buckley, Jr.

FIRST HOUSE OF DELEGATES

Dr. Kahn announced that the assignments of Reports and Resolutions were as printed in the Handbook, with the exception of Resolutions 77-12 and 77-13, which are being referred to Reference Committee No. V rather than No. III.

The Vice Speaker announced the assignment of Supplemental Reports and Resolutions which were received too late for inclusion in the Handbook and inserted into the delegates' packets.

The Speaker announced that any additional reports from the floor must be of an emergency nature only, must be by unanimous consent of the House, and must be in writing. There were none.

The Speaker announced that the Blue Shield Annual Meeting would be held at 8:00 a.m., Thursday, May 5, in the Medallion Room.

It was announced that the General Session, Friday, May 6, 11:00 a.m., in the Medallion Room would feature the President's Guest Speaker, William F. Buckley, Jr.

It was announced that a joint FLAMPAC-Auxiliary Luncheon would be held Friday, May 6, at 12:15 p.m. in the Bal Masque Room, with guest speaker Richard M. Scammon, Director of the Elections Research Center in Washington, D.C.

It was announced that there would be a dinner-dance for all FMA members and their guests at 7:30 p.m. on Friday, May 6, in the Bal Masque Room, immediately following the President's Reception.

The First House recessed at 6:00 p.m., to reconvene on Saturday, May 7, 1977, at 3:00 p.m.



Most of those who toll to produce these pages monthly turned out for the Editor's Dinner during the Annual Meeting. Front row: J. Lee Dockery, M.D., Chairman of the Council on Scientific Activities, and Mrs. Dockery, Gainesville; Mrs. Gerold L. Schiebler, and the Editor, Dr. Schiebler, Gainesville; Mrs. F. Norman Vickers, Pensacola; Mrs. Louise Rader, Managing Editor, Jacksonville; and Dr. Vickers, Book Review Editor. Standing: Mr. Edward D. Hagan, Executive Editor, Jacksonville; Associate Editor Clyde M. Collins, M.D., Jacksonville; Assistant Editor Louis B. St. Petery, M.D., Tallahassee; Historical Editor William M. Straight, M.D., Miami; Associate Editor E. Charlton Prather, M.D., Tallahassee; Mrs. A. Lee Messer and Dr. Messer, Assistant Editor, St. Petersburg; and Assistant Editor Theodore J. Marshall, M.D., Pensacola.

Second House of Delegates

The Second Meeting of the House of Delegates convened at 3:00 p.m., Saturday, May 7, 1977, in the Bal Masque Room of the Americana Hotel, Bal Harbour, Florida, with Dr. Charles J. Kahn, Speaker of the House, presiding.

Dr. John Carlson, Chairman of the Credentials Committee, reported that 227 delegates were present with 39 component societies represented, constituting a quorum, and moved the delegates be seated. The motion carried.

Delegates

ALACHUA—O. Frank Agee, M.D.; Mark V. Barrow, M.D.; Thomas D. Bartley, M.D.; Daniel B. Cox, M.D.; William B. Deal, M.D.; D. O. Jenkins, M.D.; William W. Pfaff, M.D.; Gerold L. Schiebler, M.D.; James C. Campbell, Jr., Student)

BAY—John F. Mason, Jr., M.D., (Absent - Clark A. Whitehorn, M.D.)

BREVARD—Harold F. Albert, M.D.; William J. Broussard, M.D.; James E. Carter, M.D.; Michael J. Foley, M.D.; Laudie E. McHenry, M.D.; Burton Podnos, M.D.

BROWARD—Miles J. Bielek, M.D.; Robert J. Brennan, M.D.; Bruce B. Burgess, M.D.; Andre S. Capi, M.D.; Russell B. Carson, M.D.; Milton P. Caster, M.D.; Burns A. Dobbins, M.D.; Arthur Eberly, M.D.; John M. Harper, M.D.; Rupert S. Hughes, M.D.; David C. Lane, M.D.; George P. Messenger, M.D.; Ray E. Murphy, Jr., M.D.; Franklin B. Ott, M.D.; James B. Perry, M.D.; Thomas F. Regan, M.D.; Diran M. Seropian, M.D.; Peter A. Tomasello, M.D.; Anthony J. Vento, M.D.; Juan S. A. Wester, M.D.; James C. Woulfe, M.D.; (Absent - Willis N. Dickens, M.D.; Joseph E. Gelety, M.D.; Gary Gieseke, M.D.; Raymond E. Parks, M.D.; Joseph M. Sachs, M.D.)

CAPITAL—Robert P. Johnson, M.D.; Nelson H. Kraeft, M.D.; George N. Lewis, M.D.; Jack W. MacDonald, M.D.; Robert N. Webster, M.D.

CHARLOTTE—Melvyn J. Katzen, M.D.; (Absent - Fred P. Swing, M.D.)

CITRUS—HERNANDO—W. Randall Jenkins, M.D. (Absent - William R. Lay, M.D.)

CLAY—Laurin G. Smith, M.D.

COLLIER—Fred A. Butler, M.D.; Edwin E. Dean, M.D.; Nicholas H. Kalvin, M.D.

COLUMBIA—Barney E. McRae, M.D.

DADE—Edward R. Annis, M.D.; Jose S. Bocles, M.D.; Rufus K. Broadaway, M.D.; Richard C. Clay, M.D.; Jack Q. Cleveland, M.D.; Vincent Corso, M.D.; O. William Davenport, M.D.; Joseph H. Davis, M.D.; Charles A. Dunn, M.D.; Franklin J. Evans, M.D.; Augusto Fernandez-Conde, M.D.; Miguel Figueroa, M.D.; L. Marshall Goldstein, M.D.; Norman Gottlieb, M.D.; Leo Grossman, M.D.; Abraham Gurinsky, M.D.; Henry C. Hardin, M.D.; Joseph Harris, M.D.; Norman M. Kenyon, M.D.; Maurice H. Laszlo, M.D.; Warren Lindau, M.D.; Carlos G. Llanes, M.D.; Miguel A. Mora, M.D.; Modesto M. Mora, M.D.; Harold G. Norman, M.D.; Joseph T. Ostroski, M.D.; Jorge R. Pena, M.D.; Raul V. Rivet-Arambula, M.D.; Walter M. Sackett, M.D.; Oscar S. Sandoval, M.D.; Janice K.

Sherwood, M.D.; Everett Shocket, M.D.; Samuel P. Stokley, M.D.; Chauncey M. Stone, M.D.; Mario Stone, M.D.; William M. Straight, M.D.; Charles F. Tate, M.D.; John C. Turner, M.D.; Edgar W. Webb, M.D.; Edmund Zahn, M.D.; Sheldon Zane, M.D.; (Absent - Emilio Aldereguia, M.D.; Hilario Anido, M.D.; Manuel L. Carbonell, M.D.; Isaac Egozi, M.D.; Ivor Fix, M.D.; Richard M. Fleming, M.D.; Raul E. Galliano, M.D.; Pedro J. Greer, M.D.; Julian H. Groff, M.D.; Marshall F. Hall, M.D.; Walter C. Jones, II, M.D.; James R. Jude, M.D.; Herbert S. Kaiser, M.D.; Banning G. Lary, M.D.; Milton E. Lesser, M.D.; Rose E. London, M.D.; Charles A. Monnin, M.D.; Thomas J. Noto, M.D.; Victor A. Politano, M.D.; Pedro A. Ramos, M.D.; Arvey I. Rogers, M.D.; Philip Samet, M.D.; Edward W. St. Mary, M.D.; Shreve M. Archer, Student)

DESOTO—HARDEE—GLADES—Calvin W. Martin, M.D.

DUVAL—James L. Borland, M.D.; William P. Booras, M.D.; Yank D. Coble, M.D.; Wilbert L. Dawkins, M.D.; Thomas S. Edwards, M.D.; Charles P. Hayes, Jr., M.D.; H. Joseph Hurlbut, M.D.; Walter C. Jarrell, M.D.; John C. Kruse, M.D.; Charles B. McIntosh, M.D.; Faris S. Monsour, M.D.; Daniel B. Nunn, M.D.; William L. Pearce, M.D.; B. Craig Ray, M.D.; John A. Rush, M.D.; Guy T. Selander, M.D.; Robert H. Threlkel, M.D.; William D. Walklett, M.D.

ESCAMBIA—William Reed Bell, M.D.; George L. Carr, M.D.; Eric F. geiger, M.D.; Theodore J. Marshall, M.D.; Charles F. McConnell, M.D.; John H. Whitcomb, M.D.

FRANKLIN—GULF—(Absent - Joseph P. Hendrix, M.D.)

HIGHLANDS—(Absent - Donald C. Hartwell, M.D.; Glenn V. Hough, M.D.)

HILLSBOROUGH—Francis C. Coleman, M.D.; Richard G. Connar, M.D.; Robert J. Courtney, M.D.; Irving M. Essrig, M.D.; John C. Fletcher, M.D.; J. Carlisle Hewitt, M.D.; Richard S. Hodes, M.D.; Victor H. Knight, Jr., M.D.; Joel W. Mattison, M.D.; Thomas E. McKell, M.D.; Lawrence Muroff, M.D.; John K. Petrakis, M.D.; Ralph E. Rydell, M.D.; Ralph M. Stephan, M.D.; William W. Trice, M.D.; Harold L. Williamson, M.D.

INDIAN RIVER—Donald L. Ames, M.D.; Ferdinand F. Becker, M.D.

LAKE—Fred C. Andrews, M.D.; Thomas D. Weaver, M.D.; Ernest Wollin, M.D.

LEE—Larry P. Garrett, M.D.; Francis L. Howington, M.D.; H. Quillian Jones, Jr., M.D.; Marcus M. Moore, M.D.; (Absent - John S. Hagen, M.D.)

MADISON—(Absent - Julian M. Durant, M.D.)

MANATEE—Anthony Cuva, M.D.; Robert King, M.D.; John D. Lehman, M.D.; Roger A. Meyer, M.D.

MARION—C. Brooks Henderson, M.D.; Samuel L. Renfroe, M.D.

MARTIN—Richard Q. Penick, M.D.; John F. Powers, M.D.

MONROE—J. Lancelot Lester, Jr., M.D.; (Absent - Ronald H. Chase, M.D.)

NASSAU—Jose Luis Castillo, M.D.

OKALOOSA—William W. Thompson, M.D.; Eugene R. Valentine, M.D.

ORANGE—Clarence C. Bailey, M.D.; Manuel J. Coto, M.D.; Sam F. Elder, M.D.; Edward L. Farrar, M.D.; Clarence M. Gilbert, M.D.; Allen K. Holcomb, M.D.; Rufus M. Holloway, M.D.; Donald V. Jablonski, M.D.; Franklin B. McKechnie, M.D.; James F. Richards, Jr., M.D.; James J. Schoeck, M.D.; Edward W. Stoner, M.D.; T. Byron Thames, M.D.; Robert B.

SECOND HOUSE OF DELEGATES

Trumbo, M.D.; (Absent—G. Brock Magruder, M.D.)
OSCEOLA—George Albert Gant, M.D.
PALM BEACH—Vernon B. Astler, M.D.; John D. Corbitt, Jr., M.D.; Jerry F. Cox, M.D.; James Russell Forlaw, M.D.; Luis Guerrero, M.D.; Bernard Kimmel, M.D.; Doris E. Lake, M.D.; Charles E. Metzger, M.D.; Richard Benjamin Moore, M.D.; Reginald L. Stambaugh, M.D.; Arthur L. Trask, M.D.; Dick L. Van Eldik, M.D.; Harold A. Yount, M.D.; (Absent - Thomas E. Murphy, M.D.)
PANHANDLE—Herbert E. Brooks, M.D.; William F. Brunner, M.D.
PASCO—D. L. Deal, M.D.; Nesson McCann, M.D.
PINELLAS—Emil Eddy Burns, M.D.; Thomas M. Daniel, M.D.; Charles K. Donegan, M.D.; John M. Hamilton, M.D.; Walter W. Hamilton, M.D.; Kay Knight Hanley, M.D.; Daniel S. Hellman, M.D.; David S. Hubbell, M.D.; Morris J. LeVine, M.D.; Jack A. MacCris, M.D.; William F. Mallette, M.D.; James Hugh Miller, M.D.; James M. Neill, M.D.; Donald G. Nikolaus, M.D.; David T. Overbey, M.D.; Walter H. Winchester, M.D.
POLK—Thomas M. Caswall, M.D.; Clyde E. Gibson, M.D.; John W. Glotfelty, M.D.; Robert B. Peddy, M.D.; C. Russell Smith, M.D.; Paul A. Tanner, Jr., M.D.; Luther A. Youngs, III, M.D.; Frank Zeller, Jr., M.D.
PUTNAM—Roy E. Campbell, M.D.
ST. JOHNS—William W. O'Connell, M.D.; (Absent - James J. DeVito, M.D.)
ST. LUCIE-OKEECHOBEE—Howard C. McDermid, M.D.; William H. Meyer, Jr., M.D.
SANTA ROSA—(Absent - William N. Watson, M.D.)
SARASOTA—John N. Carlson, M.D.; Kenneth C. Kiehl, M.D.; Douglas R. Murphy, M.D.; Franklin Pfeifferberger, M.D.; Richard C. Rehmer, M.D.; Karl R. Rolls, M.D.
SEMINOLE—Luis M. Perez, M.D.; Maria P. Perez, M.D.
SUWANEE-HAMILTON-LAFAYETTE—Laurent V. Radkins, M.D.
TAYLOR—John H. Parker, M.D.
VOLUSIA—Richard L. Dillard, M.D.; Michael H. Fronstin, M.D.; Irwin Leider, M.D.; Richard W. Snodgrass, M.D.; James G. White, M.D.; (Absent - Octavius B. Bonner, M.D.)
WALTON—(Absent - Howard F. Currie, M.D.)
SPEAKER OF THE HOUSE—Charles J. Kahn, M.D.
VICE SPEAKER—Sanford A. Mullen, M.D.

Dr. MacCris requested Dr. Thomas R. Busard and Dr. John D. Lehman to escort Senator Thomas M. Gallen to the podium to receive the Distinguished Layman Award.

Distinguished Layman Award Senator Thomas M. Gallen

WHEREAS, Senator Thomas M. Gallen of Bradenton, Florida, is now serving his third term in the Florida State Senate, having served three terms as a State Representative, and has rendered distinguished and able service to the medical profession and citizenry of the State of Florida; and

WHEREAS, this distinguished legislator has sponsored and fought for numerous medically related issues in the State Legislature and has been of immeasurable assistance in legislative efforts of the Florida Medical Association; and

WHEREAS, Senator Gallen sponsored legislation clarifying

Florida law to have blood considered a service rather than a product in 1969, and in 1970 led the Legislature in sustaining a veto by Governor Claude Kirk which would have mandated hospital privileges for osteopaths at all hospitals in Florida, and in 1971 was the primary sponsor of a bill to reduce the statute of limitations on malpractice from four to two years; and

WHEREAS, Senator Gallen sponsored legislation in 1972 which would protect members of the medical review committees from liability while serving on such committees and in 1973 offered legislation to protect medical review committee records, and voted to delay Senate consideration of a bill in 1974 which would have reorganized the Health and Rehabilitative Services Department, and was a primary sponsor in 1975 of the professional liability insurance package; and

WHEREAS, Senator Gallen has been a leader in protecting the rights and privileges of physicians while considering the interests and welfare of the public; and

WHEREAS, Senator Gallen is the Chairman of the Rules and Calendar Committee, Vice-Chairman of the Transportation Committee, a member of the Joint Legislative Management Committee and the Select Joint Committee on Regulatory Reform and a member of the Government Operations Committee; and

WHEREAS, Senator Gallen is a native Floridian educated at the University of Tampa and awarded a Juris Doctorate from the University of Florida College of Law, and is a member of the Florida Bar Association and the Manatee Bar Association; and

WHEREAS, Senator Gallen has been the recipient of the Junior Chamber of Commerce Good Government Award and the Service to Mankind Award of the Sertoma Club; and

WHEREAS, Senator Gallen continues to serve the citizens of Florida as a State Senator, a position from which he plays a leading role in contributing to the advancement of the profession of medicine; therefore be it

RESOLVED, that upon the unanimous vote of the Board of Governors, the Florida Medical Association, at its 103rd Annual Meeting at Bal Harbour, Florida, May 4-8, 1977, present to Senator Thomas M. Gallen its Distinguished Layman Award.

Senator Gallen expressed his appreciation for the award and noted special thanks to friends and physicians in Manatee County who have given guidance and counsel in the health problems of this state.

Dr. MacCris requested Dr. Joseph G. Matthews to escort Arthur W. Saarinen to the podium to receive a Certificate of Grateful Appreciation.

Certificate of Grateful Appreciation Arthur W. Saarinen

WHEREAS, Arthur W. Saarinen, of Fort Lauderdale, is currently President of Broward Bancshares, Inc., a bank holding company, and is also director of four subsidiary banks, Broward National Bank, Fort Lauderdale National Bank, Coral Ridge National Bank and Lauderdale Lakes National Bank; and

WHEREAS, this eminent gentleman has served on the Blue Shield Board of Directors for twenty-five years, and

WHEREAS, this dedicated executive is a native Floridian and attended the University of Florida, is past president of the Greater Fort Lauderdale Chamber of Commerce, a trustee of Fort Lauderdale University, has been active in Florida and Broward

County Bankers' Associations, and is director of the Downtown Development Authority of Fort Lauderdale, therefore be it

RESOLVED, that a certificate of Grateful Appreciation be presented to Arthur W. Saarinen as a token of the warm appreciation that the officers, members and executive staff of the Association hold for the many years of outstanding service rendered by this fine gentleman.

Dr. MaCris stated that it was a special privilege for him to present this award to Arthur Saarinen as he had known him and worked with him with Blue Shield over the past 15 years.

Mr. Saarinen stated that he was overwhelmed at receiving the award. He said that it had been a real pleasure to serve on the Blue Shield Board and he was grateful to have had the opportunity to contribute to better health care for the citizens of Florida and also to work with the medical profession which does much to make Blue Shield a success. He stated that he had been impressed with the dedication of those who have served on the Blue Shield Board. He expressed his appreciation to each physician individually and to the entire FMA for this honor.

Dr. Kahn introduced James Campbell of the Alachua Delegation, who is the student delegate from the University of Florida. He stated that Mr. Campbell had been present at every session of the House since he had been appointed.

The Speaker introduced Dr. Jere W. Annis, Vice Chairman of the Board of Trustees of the American

Medical Association.

Dr. Annis stated that as a member of the AMA Board of Trustees sent there by the FMA he felt that he should give a brief report on the AMA. He discussed National Health Insurance and stated that although physicians differ in their thoughts on this and many other subjects they must not let their differences divide them as an organization working for the best in medicine. He stated that there were three observations that could not be ignored: First, President Carter is committed to National Health Insurance and to bringing it about much sooner than was thought four months ago. Second, the public wants National Health Insurance as they perceive that concept. Third, the AMA represents us as physicians but it also represents our patients and mankind. Because of this we, as physicians, have a deep and compelling obligation to listen to them and do everything possible to fulfill our obligation to society. Further, there is a necessity for a united front in medicine. Once a decision has been reached by a majority, we must all join in and support it.

Dr. Annis stated that the AMA was founded as a federation of State Medical Societies but the time has come for medical specialty societies to be represented in the AMA House of Delegates. Dr. Annis concluded his remarks by asking for the FMA's help and support at the AMA meeting in San Francisco.



Joseph C. Von Thron, M.D., Cocoa Beach (left), and Jere W. Annis, M.D., Lakeland (right) were the principle spokesmen for opposite sides of the issue of whether FMA should support the American Medical Association's plan for national health insurance. Then the two FMA Past Presidents demonstrated by their countenances that their long standing friendship is undisturbed.



Mr. Richard M. Scammon of Washington (center) was the guest speaker for the Annual Auxiliary/FLAMPAC Luncheon. He is Director of the Elections Research Center. With him are (left) John W. Giotfelty, M.D., Lakeland, President of FLAMPAC, and (right) William W. Thompson, M.D., Ft. Walton Beach, Vice President.

Report of Reference Committee No. I

Health and Education

Dr. Charles Tate, Chairman, and his committee came forward to present the report of Reference Committee No. I, Health and Education.

Council on Scientific Activities

The motion of the reference committee to commend Dr. O. Frank Agee, Vice Chairman of the Committee on Continuing Medical Education for the outstanding scientific program developed by the specialty groups under his supervision carried.

The motion of the reference committee to replace the words "third-year" with the word "appropriate," in the report on the Fifth Pathway, carried.

The motion of the reference committee to adopt the substitute for the report of the Council on Scientific Activities carried.

Council on Scientific Activities

J. Lee Dockery, M.D., Chairman

The Council on Scientific Activities met three times during the past Association year: In Jacksonville on September 18, 1976; in Gainesville on January 8, 1977; and again in Jacksonville on February 19, 1977.

The Council's work is summarized below under the headings of its component committees:

I. — Committee on Continuing Medical Education

Dr. Yank D. Coble Jr., of Jacksonville, Chairman, has convened four meetings of the Committee on Continuing Medical Education. The first, at Hollywood-by-the-Sea on May 6,

1976, was followed by additional meetings in Jacksonville on August 28, 1976; at Tampa on January 7, 1977; and at Lake Buena Vista on January 29, 1977.

The Committee has had an active year in all phases of its program.

1. Annual Meeting Scientific Program — The Subcommittee on Annual Meeting Scientific Program, under the chairmanship of Dr. O. Frank Agee of Gainesville and in cooperation with the FMA-recognized specialty groups, has produced another outstanding scientific program for the 103rd Annual Meeting. Highlights include a Symposium on the Medical and Surgical Approaches to Stroke on Wednesday afternoon; two sessions on Basic Life Support Certification, which are open to family members of physicians as well as physicians themselves; and a special scientific program for members of the FMA Auxiliary.

2. Individual CME Program for Members — December 31, 1976, marked the end of the first three-year cycle under the Association's Continuing Medical Education Program for members that was established by the House of Delegates at its 1972 and 1973 sessions. No major problems were encountered, although as 1977 began the Committee and its staff were deluged with questions about the program. County Medical Societies were to notify FMA of those physicians who had completed the requirements for Cycle I. CME certificates will be awarded in the name of the FMA and the appropriate county medical society.

The Committee has endeavored to keep the FMA membership informed about the program through various means. As this report was prepared, the Committee had submitted for publication in *The Journal of the Florida Medical Association* an article explaining the various differences in the CME programs of FMA, the American Medical Association, and the American Academy of Family Physicians. Also, the Committee is preparing to publish a booklet entitled, "The



Reference Committee I considered reports and resolutions on Health and Education and was chaired by Charles F. Tate, M.D., Miami (standing). Others (left to right): Clarence M. Gilbert, M.D., Orlando; James R. Jude, M.D., Miami; Mrs. Cindy Kelly, Jacksonville, Recorder; William B. Deal, M.D., Gainesville; and Paul A. Tanner Jr., M.D., Auburndale.

Florida Medical Association's Continuing Medical Education Program — What Every Member Should Know."

In one of the year's major decisions affecting the program, the Committee decided to accept certification or recertification by the American Board of Internal Medicine or a subspecialty in internal medicine as fulfillment of a member's CME obligation for one three-year cycle. Acceptance of other boards will be considered by the Committee if requested by the appropriate FMA-recognized specialty groups.

During the year the Committee moved toward enhancing the role of the specialty societies in the program by standardizing the format for their CME criteria. The societies may, if they wish, require that members earn certain minimal hours within the FMA requirement in their specialties or related specialties.

3. Individual Program Approval — The Subcommittee on Program Approval, headed by Dr. Calvin W. Martin of Arcadia, has reviewed and acted upon scores of applications for FMA Mandatory Credit for various CME activities throughout the State. The vast majority of these programs (not otherwise approved for AMA Category I or AAFP Prescribed Credit) were approved by the Subcommittee. Others were not approved due to lack of relevance to medical practice.

The Committee made two basic changes in this program during the year. It rescinded the requirement that applications be submitted to FMA at least 30 days in advance of the activity. It will now consider any program for which application is made any time before the scheduled date.

The second change is in the review and evaluation procedure. Previously, a local program sponsor would submit an application for Mandatory Credit to the FMA, where the entire review and approval procedure took place within the Subcommittee on Program Approval. As of March 1, county medical society CME chairmen became involved in this review procedure. An application for approval is completed by the sponsor and forwarded immediately to the county medical society CME chairman, who evaluates the application locally and forwards the recommendation to the FMA Subcommittee on Program Approval, with which the final decision rests.

4. Accreditation — The Subcommittee on Accreditation is chaired by Dr. Henry M. Yonge of Pensacola. Since the 1976 Annual Meeting, six site surveys or surveys "in reverse" of the continuing medical education programs of six hospitals and medical organizations have been conducted. Recommendations were made to the Council on Medical Education of the American Medical Association that the following be accredited for the periods indicated:

- (a) South Florida Psychiatric Society (provisional for one year, 5/6/76 to 5/5/77).
- (b) Cedars of Lebanon Health Care Center, Miami (provisional for one year, 8/3/76 to 8/2/77).
- (c) Dade County Medical Association (provisional for one year 1/7/77 to 1/6/78).
- (d) Florida Academy of Family Physicians (provisional for one year, 1/7/77 to 1/6/78).
- (e) Tallahassee Memorial Hospital (provisional for one year, 1/29/77 to 1/28/78).

Two other applications for accreditation were reviewed but were not approved. As this report was prepared, three other applications were pending for site survey.

5. Exemptions and Extensions — Several Florida physicians have asked the Committee on CME for exemption from the CME requirements or a reduction in hours required

because of partial retirement, illness, etc. These requests have been handled for the Committee on an individual basis by the Subcommittee on Exemptions and Extensions, with Dr. Paul Tanner of Auburndale as Chairman.

6. Specialty Society Criteria — As noted earlier in this report, the Committee has worked to enhance the role of the specialty societies in the CME program. This has been accomplished through the Subcommittee on FMA-Recognized Specialty Societies, headed by Dr. E. Eddy Burns of St. Petersburg.

II. — Committee on Scientific Publications

Dr. Gerold L. Schiebler of Gainesville, Editor, and the other members of the Committee on Scientific Publications have continued to publish a quality *Journal of the Florida Medical Association*. The Committee conducted meetings on June 26, 1976, in Jacksonville; on January 28, 1977, with county medical society bulletin editors at Lake Buena Vista; and again on January 28, 1977 with JFMA's consulting editors.

In addition, monthly editorial staff conferences involving the Editor, two Associate Editors, the Executive Editor and the Managing Editor were conducted in Gainesville and Jacksonville.

1. Awards — In September, 1976, the JFMA received three awards in the annual contest sponsored by the Florida Magazine Association. The Special Issue on Dermatology (January 1976) won first place in the "Best Special Issue" category. JFMA also collected certificates of merit for Dr. William M. Straight's article, "Killer 'Canes and Medical Care," which was published in the August 1976 Historical Issue; and for general excellence in the category of non-profit association publications with less than 18,000 circulation per issue.

The January, 1976 (Special Dermatology Issue), November 1976 (Special Issue on Neurosurgery) and the December 1976 (regular issue) numbers have been entered in the Sandoz Medical Journalism Awards Contest.

2. Special Issues — Since the 102nd Annual Meeting, several outstanding special issues of the JFMA have been published. In August 1976, the Historical Issue, organized by Dr. William M. Straight, Historical Editor, was published. This was followed in October by a special issue honoring the University of Miami School of Medicine in commemoration of the 50th Anniversary of the University of Miami.

A Special Issue on Neurosurgery was published in November 1976 in cooperation with the Florida Neurosurgical Society. Dr. Albert L. Rhoton of Gainesville was Guest Editor. This outstanding issue featured a special cover designed by Dr. Frank Netter, well known medical illustrator, and papers written by members of the Florida Neurosurgical Society.

In February, a special FMA Auxiliary issue was published. The cover displayed interlocking emblems of FMA and of the Auxiliary, symbolizing the linkage between the two. The February issue combined Auxiliary news, "The Beeper," and scientific articles. Special articles and the scientific articles were selected for their appeal to feminine readership.

Preliminary discussions have been conducted for proposed future special issues on thoracic and cardiovascular surgery, rheumatology, endocrinology and poisonous plants in Florida.

3. Covers — Distinctive and attractive front covers, most of them designed by physicians or wives and friends of physicians, continued to add to the interest and quality of JFMA. Several of the previous year's covers were entered in the Florida Magazine Association Contest.

4. Typography and Design — Many typographical and design changes have been introduced to enhance the appearance of JFMA. A new modernistic logotype is now printed on the cover and is repeated on the contents page and on the first page of the scientific section. New logotypes for departmental features also have been developed. Margins have been reduced and new type faces are now used. Much of the typesetting is now done at the FMA as an efficiency and cost reduction measure.

5. New Features — Always responsive to the suggestions of the membership, the Committee has introduced some new features to JFMA. Most visible of these are an editor's column and a summary of each meeting of the FMA Board of Governors. The editor's column, entitled "*From the Editor's Desk*," is a potpourri of news capsules of medical interest taken from other publications, newsletters and other sources.

6. County Editors and Consulting Editors — The Committee has acted to improve communication with the county medical society bulletin editors and the consulting editors of the JFMA. The practice of meeting together once a year to share thoughts and suggestions has been established. Consulting editors are nominated by the FMA-recognized specialty societies. The primary function of the consulting editors is to review scientific manuscripts submitted for publication. All county society editors also have been appointed consulting editors, and two of them also serve as Assistant Editors of JFMA.

7. Liaison with County Medical Societies and Specialty Groups — Each member of the Committee on Scientific Publications has been assigned several county medical societies to visit over the next two or three years. The purpose of these visitations is to explain JFMA procedures for special issues and to invite suggestions for improvement of the publication. During the past year, a member of the Committee on Scientific Publications met with the Council on Specialty Medicine to discuss special issues.

III. — Committee on Medical Education

Dr. J. Donald Wargo of Boca Raton has served as Chairman of the Committee on Medical Education. The Committee has met in Hollywood on May 5, 1976; in Tampa on September 12, 1976; and in Gainesville on January 8, 1977. Another meeting was planned for April 16 in Tampa.

1. Joint Meeting of Medical School Advisory Committees — The Committee arranged a joint meeting of the medical advisory committees to the University of South Florida College of Medicine, the University of Florida College of Medicine; and the University of Miami School of Medicine. This meeting was conducted at the Diplomat Hotel in Hollywood, Florida on May 5, 1976. The program featured brief presentations by the three advisory committee chairmen, followed by general discussion.

2. Fifth Pathway — It will be recalled that the Committee on Medical Education provided a forum on April 11, 1976 for a dialogue on the so-called "Fifth Pathway" program between the medical school deans and State Sen. Jack Gordon of Dade County. An agreement was reached whereby the medical school deans agreed to consider for admission certain bona fide Florida residents then enrolled in foreign medical schools at the appropriate level. Passage of Part I of the examination of the National Board of Medical Examiners was considered a prerequisite for application for admission. As part of the agreement, the deans requested the National Board to schedule a special examining session for Part I in Florida during the Christmas holidays of 1976. This was to be a convenience for students, particularly those enrolled at Guadalajara in Mexico.

The National Board first agreed to the special session but then cancelled it.

The Committee has been monitoring implementation of this agreement, and it appears that all three schools have admitted or will admit a few of these Florida-resident foreign students, by satisfactory arrangements at the respective medical schools.

3. Physician Distribution — The Committee has identified for itself a role in the physician distribution problem. Members already are at work gathering data on geographical and specialty distribution. The purpose of this project is to determine where in Florida is there both oversupply and undersupply of the various specialty categories of physicians, and to bring this information to the attention of medical students and physicians who plan to settle in Florida.

4. Private Practice Program for Students, Interns and Residents — In 1975, FMA officers asked the Committee on Medical Education to develop a seminar to acquaint medical students, interns and residents with the various problems and other aspects of private practice. Such a day-long program was arranged and scheduled for the University of Miami in 1976; however, it had to be cancelled because of the prospect of poor attendance. Future efforts will focus on residents about to finish their training programs rather than students.

Also, the Committee has decided to use the medium of video tape to convey these messages, so that residents may watch them at their convenience. The Committee, with the Council's endorsement, has decided to look into the possibility of producing one pilot tape on the subject of opening a medical office. This would be circulated to the teaching hospitals of the State for viewing by residents. Feedback would be carefully evaluated prior to the production of additional tapes in the series.

Already, the Chairman of the Council on Scientific Activities and the FMA staff have had preliminary consultation with officials of the Learning Resources Center of the University of Florida regarding cost, production and technical details.

IV. — AMA Curriculum Committee

The Chairman of the Council on Scientific Activities and the Chairman of the Committee on Continuing Medical Education have been serving as Chairman and Co-Chairman, respectively, of the AMA Curriculum Committee, which is arranging the scientific program for the 1977 Mid-Winter Scientific Meeting of the AMA. This meeting will be conducted Saturday through Tuesday, December 10-13, at the Fontainebleau Hotel on Miami Beach.

A program consisting of postgraduate courses, state-of-the-art lectures and luncheon talks was developed. This was reviewed, amended and approved by the entire Committee in November 1976 and finally was presented to the AMA Council on Postgraduate Physician Education at its meeting in Philadelphia in December. Representatives of the Committee were to meet again with the AMA Council at Innisbrook in March.

V. — Research Grants

The Council on Scientific Activities serves as the Committee on Research to review application for research grants provided under the Florida Medical Foundation research program. This program, which was implemented in September, 1961, has funded research grants in excess of \$90,000. Each year the Foundation receives numerous applications for worthy research grants, which must be placed on a waiting list because of limited funds.

During 1976 the Council recommended funding, which was subsequently approved, for the following research grants totaling \$9,539:

Experimental and Clinical Use of Silicone Rods for Tendon Reconstruction and Transfer in the Lower Extremities — Joseph C. Flynn, M.D., Orlando

An Interactive Computer Model of the Skin — Marc S. Karlan, M.D., Gainesville

Quantitative Assessment of Lung Tissue Damage — Martin J. Fisher, Ph.D., Gainesville

Council on Specialty Medicine

The Reference Committee moved that a substitute for the seventh paragraph of the Council's report be adopted. A motion to amend the substitute failed, and the motion of the Reference Committee carried.

The motion to adopt the substitute for the report of the Council on Specialty Medicine carried.

Council on Specialty Medicine

John C. Fletcher, M.D., Chairman

During the 1976-77 Association year, the Council on Specialty Medicine held three meetings: August 28, 1976, in Tampa; December 11, 1976, in Orlando; and February 12, 1977, in Orlando. In addition, the Council's Subcommittee on Criteria for Recognition of Specialty Groups met once on August 27, 1976 and the Subcommittee on Physician Population Ratios met twice; on December 11, 1976, and February 11, 1977.

Presently, the Council is comprised of 36 FMA recognized specialty groups and one application is pending. During the year, the Council considered a wide range of subjects and the following is a summary of these activities.

Relative Value Studies — The Council voted to seek better liaison with the Committee on RVS in order to provide increased participation by the specialty groups in future revisions of the Relative Value Studies.

Expert Witness — It came to the Council's attention that there was an organization in the state advertising their willingness to testify on either side of a malpractice case. The Council feels that it is unethical for physicians to advertise in this manner and a recommendation was made to refer the subject of physicians advertising as medicolegal consultants to the appropriate council for investigation to identify those involved and to instruct the appropriate county medical society and specialty group to investigate their actions. It was also recommended that PIMCO compile copies of depositions from such physicians so that they can be compared to past statements and made available to FMA members.

Nurse Practice Act — On two occasions, the Council reviewed drafts of the proposed rules and regulations of the new Nurse Practice Act. Each time the draft was carefully studied and appropriate modifications were recommended. (Adopted R.C. II)

Intravenous Injections of Contrast Media and Radio-pharmaceuticals — The Florida Association of Nuclear Physicians requested that the FMA approve the practice of utilizing Nuclear Medical Technologists for giving intravenous injections of contrast media and radio-pharmaceuticals.

The FMA is of the opinion that any licensed physician may delegate procedures to his employee he deems commensurate

with the employee's education, training and demonstrated ability subject to the credentialing authority of a health care facility to which the physician is responsible.

Payment for Pap Smears — On two occasions the Council forwarded recommendations to the Board that the FMA encourage all government medical care programs and third parties, including Blue Shield, to consider pap smears as a necessary medical procedure and provide reimbursement to physicians for this procedure.

Patient Referrals from State Institutions — A report was received on the apparent unethical practice of state mental hospitals in referring patients directly to mental health centers after receiving them initially from private psychiatrists. Therefore, a recommendation was made that the FMA take all necessary action including but not limited to initiation of rule making proceedings to insure that this practice is not continued.

Data Processing — After receiving a presentation on data processing the Council suggested that the FMA examine the feasibility of establishing a data processing mechanism that would improve the administrative efficiency in ambulatory health care and eliminate insurance claim paperwork drudgery.

Nuclear Medical Technologists — The Council continued its review of the problem faced by Nuclear Medical Technologists in Florida who meet national standards for licensure but do not meet criteria established under the Florida Clinical Laboratory Act. The Council is pleased to report that this subject may soon be resolved through the promulgation of new rules and regulations for the Clinical Laboratory Act. Those interested specialty groups have indicated they are near agreement on this matter.

TB Control and Treatment in Florida — In 1974 the State closed the W. T. Edwards TB Hospital and is presently considering closing the A. G. Holley Hospital in Lantana, Florida, which is the only remaining state TB hospital. The state plan is to transfer the treatment of tuberculosis to the community hospital. The Council has recommended that the FMA take a position that the State should maintain 150 beds at A. G. Holley Hospital for specialized tuberculosis care, the funding of a demonstration project to permit the state to contract with community hospitals



The family of outgoing President Jack A. MacCris, M.D., proudly displays the portrait of him which was presented to Mrs. MacCris at the final session of the House. Left to right: mother, Mrs. T. S. MacCris; sister, Mrs. John R. McDavld; daughter, Kathryn; wife, Mrs. Janet MacCris; son, Steven; daughter-in-law, Mrs. Steven MacCris; and daughter, Barbara.

in selected areas to determine the cost of this care in Florida, and the maintenance of hospital and community program funding levels to assure a safe transition from state hospital to community care.

Recognition of Specialty Groups — The Council has spent a great deal of time trying to develop a new and meaningful criteria for FMA recognition of specialty groups. Recommendations were forwarded to the Board of Governors concerning this subject.

During this reporting period, the Florida Thoracic Society received formal FMA recognition and the Council has also recommended that the Florida Federation of Clinical Oncologists be recognized.

Physician Population Ratios — The Council is presently conducting a survey of all FMA recognized specialty groups to determine what the "optimal number" of physicians in Florida by specialty would be. Information is also being gathered from all sources at both the state and national levels relative to physician population ratios for medical specialties in Florida.

Supplemental Report Council on Specialty Medicine

The motion that a substitute for the recommendation in the Council on Specialty Medicine's supplemental report be adopted carried.

Supplemental Report Council on Specialty Medicine Tuberculosis Control in Florida

Tuberculosis case rates in Florida have been decreasing over the last decade; however, due to a 42% increase in



Gerold L. Schiebler, M.D., Editor of *The Journal*, presents the Annual Editor's Award, to Mrs. A. R. MacPherson of Maitland. Mrs. MacPherson accepted the award on behalf of Mrs. James D. Moody of Orlando, whose painting "Lost Children" was adjudged the winner and appears on the cover of this issue of *The Journal*.

population, the actual number of cases is rising. A major portion of this increase is occurring among Florida's expanding share of the nation's migrant workers and other transient population elements. The Council is of the opinion that the need for long term sanatorium care has passed but specialized beds are still needed in a state facility for care of Florida's most difficult and recalcitrant patients.

Even though the number of tuberculosis cases is rising, the amount of state money for all programs has not been increased or has relatively decreased. The legislature is presently considering closing the A. G. Holley Hospital in Lantana which is the only remaining state facility for the care of tuberculosis.

Recommendation

Therefore, the Council recommends the adoption of the following resolution:

WHEREAS, Florida's tremendous population growth compared with other states has resulted in a unique and remarkable increase in the prevalence of tuberculosis over the past 18 years, and

WHEREAS, a major portion of this increased prevalence is occurring among Florida's expanding share of the nation's migrant workers and other transient population elements which have special need for carefully structured treatment services to assure effective therapy, and

WHEREAS, Florida's community tuberculosis control program has been inadequately funded and developed to maintain effective control of the disease in the absence of a state hospital for the care of highly mobile patients with multiple psycho-social problems, and

WHEREAS, advances toward the increased utilization of community hospitals for the treatment of tuberculosis must be made on the basis of factual cost data and assurances of continued effective disease control, and

WHEREAS, reductions in state hospital utilization and shorter hospital stays have a direct and immediate impact upon the need for increased out-patient services and community control program resources, therefore be it

"RESOLVED, that the FMA recommends that the State of Florida maintain 125-150 beds at A. G. Holley Hospital for tuberculosis care of problem patients; and be it further

"RESOLVED, that the FMA recommends the funding of a demonstration project to permit the State to contract with community hospitals in selected areas to determine the cost of the routine tuberculosis care in Florida, and be it further

"RESOLVED, that the FMA recommends the continuation of hospital and community program funding levels to assure a safe transition from hospital to community care."

Report of Board of Governors Referrals by the House of Delegates

Pap Smears

Recommendation No. 1

The Reference Committee reported it had reviewed the report and recommendation on Pap Smears and felt that this recommendation is specific for a health maintenance procedure in a doctor's office. "The same would apply to other preventive procedures not covered by insurance,

such as blood counts, routine chest x-rays, etc., and this is beyond the prerogative of this Reference Committee."

The motion of the Reference Committee that the report on Pap Smears and Recommendation No. 1 be referred back to the Board for further study carried. (See Report of Board of Governors, Page 442).

FMA Councils and Committees Section Council on Scientific Activities

The motion of the Reference Committee that the amount shown in the report be corrected to "\$9,539.00", carried.

The motion of the Reference Committee that the Board's report on the Council on Scientific Activities be adopted as corrected carried. (See Report of Board of Governors, Page 449).

1977 Annual Meeting Scientific Program

The motion of the Reference Committee that the Board's report on the 1977 Annual Meeting-Scientific Program be adopted carried. (See Report of Board of Governors, Page 449).

Council on Specialty Medicine "Medicalegal Consultants"

The motion of the Reference Committee that the Board's report on "Medicalegal Consultants" be adopted carried. (See Report of Board of Governors, Page 450).

Nurse Practice Act

The motion of the Reference Committee that the Board's report on the Nurse Practice Act be adopted carried. (See Report of Board of Governors, Page 450).

Intravenous Injections

The Reference Committee moved a substitute for the Report of the Board of Governors, Council on Specialty Medicine, Intravenous Injections. A motion from the floor to amend the substitute carried. (See Report of Board of Governors, Page 450).

Diabetes Screening Program

The motion of the Reference Committee that



Mrs. Gloria Nunn of Jacksonville greets David C. Sabiston, M.D., of Durham, N.C., who was a guest speaker at the Section on Thoracic and Cardiovascular Surgery. Mrs. Nunn's husband, Daniel B. Nunn, M.D., was Program Chairman for the Section.

the Board's Report on the Diabetes Screening Program be adopted carried. (See Report of Board of Governors, Page 450).

Blue Shield

The motion of the Reference Committee that the Board's Report on Blue Shield be adopted carried. (See Report of Board of Governors, Page 450).

Patient Referrals Recommendation No. 18

The motion of the Reference Committee that the Board's Recommendation No. 18, Patient Referrals, be adopted carried. (See Report of Board of Governors, Page 450).

Specialty Group Recognition

The motion of the Reference Committee that the Board's Report on Specialty Group Recognition

be adopted carried. (See Report of Board of Governors, Page 450).

Subcommittee on Administrative Medicine

The motion of the Reference Committee that the Board's Report on the Subcommittee on Administrative Medicine be adopted carried. (See Report of Board of Governors, Page 450).

Resolution 77-19

Continuing Medical Education Records Hillsborough County Medical Association

The motion of the Reference Committee to amend Resolution 77-19 by adding in the last "Resolved" the words "and feasible" carried.

The motion of the Reference Committee that Resolution 77-19 be adopted as amended carried.

Resolution 77-19

Continuing Medical Education Records

RESOLVED, that the Florida Medical Association's Committee on Continuing Medical Education be requested to

explore methods for reporting and maintaining CME records as used by the American Medical Association and by many national specialty societies, and be it further

RESOLVED, that the Florida Medical Association develop as soon as practical and feasible an appropriate centralized computer system in the FMA headquarters for maintaining CME records.

The chairman of the reference committee thanked Dr. J. Lee Dockery, Chairman of the Council on Scientific Activities, and Dr. John C. Fletcher, Chairman of the Council on Specialty Medicine, for their valuable contributions to the deliberations of this reference committee.

He also thanked the members of the committee, Drs. William B. Deal, Clarence M. Gilbert, James R. Jude, and Paul A. Tanner Jr., and the AMA Delegate Advisor, Dr. Rufus K. Broadaway, for their dedicated participation in the hearings of the Committee and the preparation of this report. The chairman thanked Mrs. Cindy Kelly, their secretary, for her efficiency in preparing the report, and Mr. Edward D. Hagan of the FMA Staff, for his wise counsel to the Committee.

The motion that the report of Reference Committee No. I be adopted as a whole, as amended, carried.



The Past Presidents of the Association gathered once again during the Annual Meeting for their traditional breakfast. Seated: H. Phillip Hampton, M.D., Tampa (1965); Ralph W. Jack, M.D., Miami (1959); Jere W. Annis, M.D., Lakeland (1958); Walter C. Jones, M.D., Miami (1941); Samuel M. Day, M.D., Jacksonville (1964); Warren W. Quillian, M.D., Coral Gables (1963); and Henry J. Babers Jr., M.D., Gainesville (1969). Standing: James T. Cook, M.D., Marianna (1970); Jack Q. Cleveland, M.D., Coral Gables (1968); W. Dean Steward, M.D., Marianna (1967); George S. Palmer, M.D., Tallahassee (1966); William C. Roberts, M.D., Panama City (1957); Leo M. Wachtel, M.D., Jacksonville (1960); William J. Dean, M.D., St. Petersburg (1972); and Vernon B. Astler, M.D., Boynton Beach (1975).

Report of Reference Committee No. II

Public Policy

The Vice Speaker assumed the chair and called for the report of Reference Committee No. II.

Dr. Calvin W. Martin, Chairman, and his committee came forward to present the report of Reference Committee No. II, Public Policy.

Council on Medical Services

The Reference Committee commended Dr. J. Russell Forlaw, Chairman of the Council on Medical Services, for his excellent report and recognized the component committees for their devoted and time consuming efforts throughout the year.

The motion of the Reference Committee to approve the Report of the Council on Medical Services as printed in the Handbook carried.

Council on Medical Services

J. Russell Forlaw, M.D., Chairman

During this reporting period, all of the committees under the Council on Medical Services have been active in specific programs to upgrade medical services in Florida. Several committees recommended and planned major statewide conferences that were sponsored by the Florida Medical Foundation. Other committees conducted extensive studies in the areas of health related problems.

Council meetings were held in Miami on September 26, 1976, and February 27, 1977. The following is a consolidated report

giving a brief description of each committee's activities for the year.

The Committee on School Health — remains the official School Health Medical Advisory Committee to the Department of Education and Health Program Office, Department of HRS. Over the past year the committee continued its review of the various special county health education projects around the state.

The scoliosis screening program developed by the Citrus Orthopaedic Society was reviewed with a recommendation going to the Commissioner of Education that scoliosis screening be incorporated as part of a school screening program.

Recommendations were made concerning school trampoline injuries, treatment of school children afflicted with pediculosis or scabies, TB testing of school personnel, sex education and management of the asthmatic student. In addition, the committee went on record in support of state funding of the School Health Services Act of 1974.

The School Health Medical Advisory Committee was proud to have co-sponsored the 1977 Florida Conference on School Health held in Orlando on March 4-5. Other co-sponsors included the Department of Education, Department of HRS and the FMA Auxiliary. This meeting was designed to provide a working forum for school personnel, physicians, voluntary health representatives and concerned citizens.

The Committee on Drug Abuse — completed its study of the availability and utilization of medical services by Florida's 29 residential drug abuse treatment centers. The 410-page report was well received by the Drug Abuse Program Office. A copy of the report was forwarded to Robert L. DuPont, M.D., Director, National Institute on Drug Abuse, for his review and comment.

The Committee on Drug Abuse was invited to present the findings of the drug abuse report to the Southeast Regional Substance Abuse Conference in Tampa on February 17, 1977. A



Matters of Public Policy commanded the attention of Reference Committee II and its Chairman, Calvin W. Martin, M.D., Arcadia (standing). Others (left to right): John C. Kruse, M.D., Jacksonville; Janice K. Sherwood, M.D., Miami Beach; Mrs. Joan Kussmaul, Jacksonville, Recorder; Franklin Pfelffenberger, M.D., Sarasota; Michael J. Foley, M.D., Melbourne; and Charles K. Donegan, M.D., St. Petersburg, AMA Delegate.

similar presentation was made by the committee's chairman at the Mental Health Program Office Advisory Council meeting in Tallahassee on February 22, 1977.

With the conclusion of the contract for this project, a little over \$13,000 in funds has been returned to the Department of HRS with a committee recommendation that the funds be utilized for developing a standardized format for medical records kept in the treatment centers.

The committee is pleased to announce that the Florida Association of Drug Abuse Treatment and Education Programs has requested that the FMA Drug Abuse Committee serve as their official medical advisory committee. The D.A.T.E. Association is a newly formed non-profit organization representing drug abuse treatment and education programs in Florida.

The Committee on Public Health — has monitored the national flu immunization program and is concerned over the bad publicity this program received, as it appears that this adverse publicity had a negative effect on all immunization programs.

During the year the committee made recommendations concerning support for increased state funding for county health departments and suggested that the FMA seek legislation that would require that inspection of food service establishments be conducted only under supervision of the state health agencies and their component county health departments. Also, that the present duplication of these inspections by the Division of Hotels and Restaurants, Department of Business Regulations, be eliminated.

Presently the Committee is studying what form of liaison the Florida Medical Association should have with home health care agencies.

The Committee on Rural Health — is currently planning the Florida Medical Association's second "Physician Recruitment Conference" for communities in need of physicians. A post-conference questionnaire indicates the first conference held in April-1976 was well received by the community representatives in attendance. The 1977 meeting will be held in either October or November.

The Committee on Rural Health held meetings on December 2, 1976, in Jacksonville, and March 16, 1977, in Inverness. During these meetings the committee studied the subject of physician availability in rural areas. The FMA committee continues to participate in the Florida Committee on Rural Health which represents a number of statewide organizations.

The Committee on Emergency Medical Services — remains one of the most active committees in the Florida Medical Association. On September 11 and 12, the Florida Medical Foundation sponsored a multi-disciplinary Conference on the Identification of Needs and Standards for In-hospital Critical Care. The Committee on Emergency Medical Services acted as the planning group for this unique conference. The meeting was held at the Host International Hotel in Tampa. More than 150 persons attended the two-day gathering which was funded by a grant from the EMS Section, Health Program Office. The proceedings of this conference are being published and will be available through the Health Program Office, Department of HRS.

During this reporting period, the committee held one two-day meeting on December 4-5, 1976, and one three-day meeting on February 18-20, 1977. Recommendations were made concerning state disaster plans, advanced life-support training for physicians, hospital critical care capabilities, wheelchair ambulances, written transfer agreements, commercial information systems and the 911 emergency phone system.

Presently, the Committee is drafting proposed legislation regarding physician supervision of the training and activities of emergency medical personnel (EMT I/EMT II/Paramedic).

Council on Specialty Medicine (Nurse Practice Act)

Committee on Allied Health Professions (Nurse Practice Act)

The motion of the Reference Committee that the report of the Council on Specialty Medicine (See Report of the Council on Specialty Medicine, Page 425) and the Board's report on the Committee on Allied Health Professions' activities regarding the Nurse Practice Act (See Report of Board of Governors, Page 450) be adopted as printed in the Handbook carried.

Report of Board of Governors

Board Actions

Hospital Staff Privileges for Non-Physicians

The Reference Committee moved that Board Action No. 12 and Recommendation No. 6 restricting Hospital staff privileges for non-physicians be adopted. A motion from the floor to amend Board Action No. 12 and Recommendation No. 6 failed, and the motion of the Reference Committee carried. (See Report of Board of Governors, Page 444).

FMA Councils and Committees

Council on Medical Services

County Health Departments

The motion of the Reference Committee that the Board's Report expressing continued support for a substantial increase in state funding for county health departments be adopted as printed in the handbook carried. (See Report of Board of Governors, Page 448).

Scoliosis Screening

The motion of the Reference Committee that the Board's Report on scoliosis screening be adopted as printed in the handbook carried. (See Report of Board of Governors, Page 448).

Council on Medical Services

The Reference Committee concurred in the

Board of Governors commendations of the Council on Medical Services and its committees on Drug Abuse and Emergency Medical Services and moved that this report be adopted as printed in the handbook. The motion carried. (See Report of Board of Governors, Page 448).

Duplication of Restaurant Health Inspections

The motion of the Reference Committee that the Board's Report on the duplication of restaurant health inspections be adopted as printed in the handbook carried. (See Report of Board of Governors, Page 448).

CME Course—Advanced Life-Support Training

The motion of the Reference Committee that the Board's Report concerning a CME Course for advanced life-support training be adopted as printed in the handbook carried. (See Report of Board of Governors, Page 448).

Hospital Survey

The Motion of the Reference Committee that the Board's Report authorizing a survey on the critical care capabilities of Florida's hospitals be adopted as printed in the handbook carried. (See Report of Board of Governors, Page 448).

State Disaster Plan

Recommendation No. 11

The motion of the Reference Committee that the Board's Report on the State's Disaster Plan and Recommendation No. 11 be adopted as printed in the handbook carried. (See Report of Board of Governors, Page 448).

Written Transfer Agreements

Recommendation No. 12

The motion of the Reference Committee that the word "patient's" be corrected to read "patient" and that the Board's Report on written transfer agreements and Recommendation No. 12 be adopted as corrected carried. (See Report of Board of Governors, Page 449).

911 Emergency Phone System

Recommendation No. 13

The motion of the Reference Committee that the Board's Report on the 911 Emergency phone

system and Recommendation No. 13 be adopted as printed in the handbook carried. (See Report of Board of Governors, Page 449).

Pediculosis and Scabies in Schools

Recommendation No. 14

The motion of the Reference Committee that the Board's Report concerning pediculosis and scabies in schools and Recommendation No. 14 be adopted as printed in the handbook carried. (See Report of Board of Governors, Page 449).

State Funding - School Health Act of 1974

Recommendation No. 15

The motion of the Reference Committee that the Board's Report concerning state funding of the School Health Services Act of 1974 and Recommendation No. 15 be adopted as printed in the handbook carried. (See Report of Board of Governors, Page 449).

Locum Tenens for Rural Physicians

Recommendation No. 16

The motion of the Reference Committee that the Board's Report on locum tenens for rural physicians and Recommendation No. 16 be adopted as printed in the handbook carried. (See Report of Board of Governors, Page 449).

D.A.T.E. Association—Medical Advisory Committee

Recommendation No. 17

The motion of the Reference Committee that the Board's Report on the drug abuse treatment and education programs and Recommendation No. 17 be adopted as printed in the handbook carried. (See Report of Board of Governors, Page 449).

Committee on Allied Health Professions

The motion of the Reference Committee that the Board's report on the Committee on Allied Health Professions concerning the definition, criteria for recognition, and recognition of allied health professions be adopted as printed in the handbook carried. (See Report of Board of Governors, Page 450).

Committee on Sports Medicine

The motion of the Reference Committee that

the Board's report on the Committee on Sports Medicine regarding its designation as a standing committee be adopted as printed in the handbook carried. (See Report of Board of Governors, Page 451).

The motion of the Reference Committee that the Board's report on the Committee on Sports Medicine regarding school trampoline injuries be adopted as printed in the handbook carried. (See Report of Board of Governors, Page 451).

The motion of the Reference Committee that the Board's report on the Committee on Sports Medicine regarding courses in athletic training for physical education majors be adopted as printed in the handbook carried. (See Report of Board of Governors, Page 451).

Committee on Allied Health Professions

The Reference Committee commended Dr. Luis Perez, Chairman, and the members of the Committee on Allied Health Professions for their good work throughout the year and especially for the committee's participation on the Special Subcommittee on the Joint Practice of Medicine and Nursing.

The motion of the Reference Committee that the report of the Committee on Allied Health Professions as printed in the handbook carried.

Committee on Allied Health Professions

Luis M. Perez, M.D., Chairman

The Committee held two meetings in Orlando during the 1976-77 Association year: August 8, 1976, and March 13, 1977. In addition, the Committee's specialty Subcommittee on the Joint Practice of Medicine and Nursing met on August 18, 1976, and January 26, 1977.

The Committee on Allied Health Professions provides liaison with the following health professions:

1. Florida Dental Association
2. American Association of Medical Assistants Florida State Society
3. Florida Dietetic Association
4. Florida Society of Medical Technologists
5. Florida Nurses Association
6. Florida Association of Dispensing Opticians
7. Florida Pharmaceutical Association
8. Florida Chapter, American Physical Therapy Association
9. Florida Podiatry Association
10. Florida Society of Radiologic Technologists
11. Florida Veterinary Medical Association
12. Florida Society for Respiratory Therapy
13. Florida Academy of Physician's Assistants

On two occasions, meetings were held with representatives of the above organizations. During these meetings, frank and meaningful discussions were held on legislation and other

matters that affect health professionals.

For the past year, the Committee has monitored the writing of the rules and regulations for the new Nurse Practice Act and provided testimony at several public hearings. Representatives of the committee testified that it is essential that the rules require physician supervision over the activities of the Nurse Practitioner. Committee members also testified at public hearings on the rules and regulations for the new Drug Substitution Act.

During this reporting period, the Committee recommended and received approval from the Board to formally recognize two more allied health professions:

1. Florida Society for Respiratory Therapy
2. Florida Academy of Physician's Assistants

The FMA definition of an allied health profession was revised and the criteria for recognition has been expanded. Certain health experts are predicting inter-professional conflict in the future as a result of the ever-growing health manpower, therefore, the Committee's role in providing liaison with allied health professions is becoming more important each year.

Committee on Voluntary Health Agencies Report

The Reference Committee congratulated Dr. Robert C. Palmer for his fine efforts as a one-man committee for the FMA Committee on Voluntary Health Agencies. The motion of the Reference Committee that the report of the Committee on Voluntary Health Agencies be adopted as printed in the handbook carried.

Committee on Voluntary Health Agencies

Robert C. Palmer Jr., M.D., Chairman

During this reporting period, the Committee on Voluntary Health Agencies held two meetings in Tampa: September 17, 1976, and February 4, 1977. Representatives from FMA Recognized Voluntary Health Agencies attended the above committee meetings and very meaningful discussions were held concerning: adverse publicity regarding fund raising costs, quackery, the effects reorganization of the Department of HRS has had on VHA programs and suggested revisions of the FMA recognition application form.

Fifteen voluntary health agencies received recognition during the 1976-77 Association year:

1. Florida Chapter, Arthritis Foundation
2. Florida Division, Leukemia Society of America
3. American Heart Association, Florida Affiliate
4. Florida Division, American Cancer Society, Inc.
5. Florida Epilepsy Foundation, Inc.
6. Florida Coordinating Council of the National Kidney Foundation
7. Florida Association for Retarded Citizens
8. The National Foundation, March of Dimes
9. Florida Lung Association
10. United Cerebral Palsy of Florida, Inc.
11. Easter Seal Society for Crippled Children and Adults of Florida, Inc.
12. National Multiple Sclerosis Society, Southeast Region
13. Mental Health Association of Florida, Inc.
14. Florida Society for the Prevention of Blindness, Inc.
15. Muscular Dystrophy Association, Inc., Florida District



This exhibit, "Thoracoscopy In Children," was awarded First Place in the annual Scientific Exhibit competition sponsored by the Committee on Continuing Medical Education. The exhibit was shown by Bradley M. Rodgers, M.D., Alvin H. Felman, M.D., James L. Talbert, M.D., William H. Donnelly, M.D., Eva Hvizdala, M.D., and Richard A. Murbach, M.D., of the University of Florida College of Medicine, Gainesville.

Most voluntary health agencies feel that some doctors are not aware of all the services provided by VHA's. Therefore, a recommendation was made, which received Board approval, to expand the VHA section of the FMA Directory to provide additional information on voluntary health agency programs.

Presently, the Committee is completing the review of applications for the 1977-78 Recognition Program. A recommendation has been made to approve the applications of 10 voluntary health agencies and additional information has been requested from the remaining applicants.

Committee on Voluntary Health Agencies Supplemental Report

The motion of the Reference Committee that the Committee on Voluntary Health Agencies' supplemental report be adopted as presented carried.

Supplemental Report Committee on Voluntary Health Agencies

The Committee on Voluntary Health Agencies has now completed the review of all applications received for the Florida Medical Association's 1977-78 Voluntary Health Agency Recognition Program, and recommends official FMA recognition for the following VHA's.

1. Florida Chapter, Arthritis Foundation
2. Florida Division, Leukemia Society of America
3. American Heart Association, Florida Affiliate
4. Florida Division, American Cancer Society, Inc.
5. Florida Epilepsy Foundation, Inc.
6. Florida Coordinating Council of the National Kidney Foundation
7. Florida Association for Retarded Citizens
8. The National Foundation, March of Dimes
9. Florida Lung Association
10. United Cerebral Palsy of Florida, Inc.
11. Easter Seal Society for Crippled Children and Adults of Florida, Inc.
12. National Multiple Sclerosis Society, Southeast Region
13. Mental Health Association of Florida, Inc.

14. Florida Society for the Prevention of Blindness, Inc.
The Muscular Dystrophy Association, Inc., Florida District,
did not apply for recognition for 1977-78.

Committee on Sports Medicine

The motion of the Reference Committee that the report of the Committee on Sports Medicine be adopted as printed in the handbook carried.

Committee on Sports Medicine Bernard Kimmel, M.D., Chairman

During the 1976-1977 Association year, the Committee on Sports Medicine held three meetings: June 19 and September 11, 1976, in Tampa; and December 11, 1976, in Miami.

The committee was first appointed in early 1976 as a special committee of the Board and was originally named the "Committee on Sports Injuries". At the June organizational meeting a recommendation was made, which received Board approval, to change the committee's name to the "Committee on Sports Medicine". The Board also decided to make the group a standing committee and to place it under the Council on Medical Services, subject to the appropriate by-law change at the 1977 Annual House of Delegates Meeting.

Over the past year, recommendations were made concerning teacher credit for in-service training; adding the expertise of an obstetrician-gynecologist and pediatrician to the committee; funding grade and high school athletic programs; heat, fluid and electrolyte balance; trampoline injuries and female athletic programs.

Presently, the committee is working on a program for developing athletic trainers for school athletic programs. In addition, the committee is trying to establish liaison with other groups involved in the area of athletics.

Resolution No. 77-8

The motion of the Reference Committee that Resolution No. 77-8 be referred to the Board of Governors for their consideration and appropriate action by the Committee on Sports Medicine carried.

Resolution 77-8 High School Sports Brevard County Medical Society

(NOT ADOPTED-REFERRED TO THE BOARD OF GOVERNORS.)

WHEREAS, high school and junior high school spring sports (tennis, golf, swimming, track, baseball and softball) involve more athletes — both boys and girls — than at any other time during the school year and,

WHEREAS, most of these activities overlap with winter sports and commence in midwinter when much of this competition takes place in inclement weather, and

WHEREAS, they discontinue these sports long before school is out so as not to interfere with spring football practice, and this leaves the majority of high school athletes without competition the last 4-6 weeks of school, and

WHEREAS, spring football involves only the male sex and few in number compared with the total spring sports picture, and

WHEREAS, football in Florida's High School Program is approaching professionalism, student athletes are spending up to 4½ hours per day for 4-5 months of the year, this of course, is interfering with academic achievement and utilizes most of the students' extra curricular activities, and

WHEREAS, many serious injuries often causing permanent disability occur during spring football and the State of Florida is presently involved in numerous law suits, some involving millions of dollars, concerning these injuries, some of which have occurred during spring football practice, be it

RESOLVED, that the FMA recommend to the Florida High School Athletic Association that spring sports commence later in the season and further, be it

RESOLVED, that the FMA recommend to the Florida High School Athletic Association to discontinue spring football practice in all schools under its jurisdiction.

The Reference Committee expressed its appreciation to all the members of the Florida Medical Association who appeared and presented testimony on all of the issues concerning FMA public policy. A special thanks was conveyed to Dr. Charles K. Donegan, Pinellas County, who represented the AMA delegates at the meeting of this Reference Committee. The Reference Committee also thanked Mrs. Joan Kussmaul and Mr. Robert J. Harvey of the FMA staff for their assistance in the preparation of the Reference Committee's report.

The motion of the Reference Committee that the report of Reference Committee No. II be adopted as a whole carried.



House Speaker Charles J. Kahn, M.D., Pensacola, presents FMA Certificates of Appreciation to James W. Walker, M.D., Jacksonville (upper photo), and Donn L. Smith, M.D., (lower photo). Dr. Walker was Secretary-Treasurer of FMA for several years and now is President of Professional Insurance Management Company (PIMCO). Dr. Smith resigned several months ago as Dean of the University of South Florida College of Medicine, but remains on the faculty there.





Annual Meeting Photo Highlights

1, Drs. J. A. MaCris and E. L. Farrar; 2, Mrs. W. H. Mathews, Mrs. J. L. Talbert, and Mrs. J. Jude; 3, Group of Auxiliary Members; 4, Mrs. J. W. Herbert and Dr. S. M. Day; 5, Dr. W. D. Steward; 6, Mr. M. H. Lopez and Dr. R. J. Stambaugh; 7, Mrs. R. B. Moore and Mrs. W. H. Harrison; 8, Mrs. E. R. Simmons; 9, Mrs. W. H. Harrison; 10, Dr. J. A. Rush; 11, Dr. G. Selander; 12, Dr. J. Q. Cleveland; 13, Dr. C. F. McConnell; 14, Dr. J. B. Perry; 15, Dr. J. H. Davis; 16, Dr. J. W. Annis; 17, Dr. J. W. Glottelty; 18, Drs. F. S. Monsour and Y. D. Coble, Jr.; 19, Dr. I. M. Essrig.



FMA DINNER DANCE

BAL MASQUE
FRIDAY, MAY 8, 7:30 P.M.



RESERVATIONS AVAILABLE AT
FMA REPRESENTATIVE DESK

53

- 1, Some Auxiliary members; 2, Mrs. R. B. Moore and Dr. J. C. Von Thron; 3, Mrs. R. B. Moore and Mrs. W. H. Harrison; 4, Dr. and Mrs. S. M. Day; 6, Dr. B. C. Thompson and Dr. and Mrs. V. B. Astler; 7, New Auxiliary officers; 8, Mrs. C. Henderson and Mrs. W. H. Harrison; 9, Guests at Dinner Dance; 10, Drs. Pfeifferberger, M. J. Foley and C. K. Donegan; 11, Dr. and Mrs. J. W. Annis; 12, Dinner Dance guests; 13, Dinner Dance door prize presentation; 14, Auxiliary members; 17, Dr. J. W. MacDonald, Tallahassee; 18-20, More Dinner Dance photos; 21, Mrs. Mae White; 22, Mrs. C. H. Gilliland, Mrs. R. B. Moore, Mrs. J. I. Thompson, and Mrs. T. B. Thames; 23, Mr. J. W. Herbert, Dr. J. W. Walker, and Dr. J. G. Matthews; 24, State Sen. Tom Gallen (at lectern); 25, Dr. C. W. Martin; 26, Dinner Dance guests; 27, Dr. and Mrs. D. G. Nikolaus; 28, Dr. W. H. Parham; 29, Mr. Rollie Hinton and L. C. Murray; 31, Dr. C. J. Kahn; 32, Mrs. F. P. Swartz.



and Mrs. C. Larsen; 34, Dr. M. J. Foley; 35, Mrs. W. H. Mathews and Mrs. C. B.
 Anderson; 36, Mrs. W. H. Harrison, Dr. E. G. Peek, Jr., and Dr. W. B. Deal; 37,
 L. B. Garrett and Dr. H. Q. Jones; 38, Mrs. J. C. Garlington and Mrs. D. B.
 Ann; 39, Mr. W. J. Stansell and Mrs. Elsie Trask; 40, Dr. J. W. Glottelty and Mr.
 M. Scammon; 41, Dr. R. P. Johnson; 42, Mrs. J. T. Blackburn and Mrs. T. B.
 James; 44, Dr. K. C. Kiehl; 45, Dr. and Mrs. J. L. Borland, Jr.; 46, Dr. and Mrs. V.
 Astler and Mrs. W. H. Parham; 47, Secretary of State and Mrs. Bruce
 Mathers and guest; 48, Committee meeting in progress; 49, Dr. and Mrs. S.
 Anfree and guest; 50, Dr. and Mrs. O. W. Davenport; 51, Dinner Dance guests;
 Dr. and Mrs. J. R. Forlaw and Dr. and Mrs. E. G. Peek, Jr.; 54, Dr. J. Hamilton;
 Mrs. J. G. White; 56, Dr. R. J. Stambaugh; 57, Quilt made by Palm Beach
 County Auxiliary for Mrs. R. B. Moore.





1, Mrs. C. B. Henderson and Mrs. W. H. Harrison; 2, Dr. and Mrs. D. L. Van Eldik and Mrs. R. B. Moore; 3, Mrs. M. Ekwall and Mrs. T. B. Thames; 5, Dr. J. G. White; 6, Dr. D. G. Nikolaus; 7, Dr. H. Q. Jones; 8, Dr. J. C. Von Thron; 9, Dr. F. T. Holland; 10, Dr. P. A. Tanner, Jr.; 11, Dr. W. Dean Steward; 13, Dr. E. G. Peek, Jr.; 14, Drs. K. R. Rolls and R. E. Windom; 15, Dr. F. C. Andrews; 17, Dr. J. Hamilton; 18, Dr. E. R. Annis; 19, Dr. F. J. Evans.

Report of Reference Committee No. III

Finance and Administration

The Speaker called for the report of Reference Committee III, Finance and Administration. Dr. Robert Johnson, Chairman, and his committee came forward to present the report of Reference Committee No. III, Finance and Administration.

Report of Board of Governors Recommendation No. 19

The Reference Committee moved a substitute for Recommendation No. 19 of the Board of Governors. A motion by the Reference Committee that this substitute be adopted carried.

The motion of the Reference Committee that the Report of the Board of Governors be adopted as changed, with the exception of those items referred to other reference committees, carried.

Report of Board of Governors

Jack A. MaCris, M.D., Chairman

Your Board of Governors has held 4 meetings during the past Association year, 1976-77. The Board met in regular session on May 9, 1976, October 7-9, 1976, January 15, 1977, and March 19-20, 1977.

The many items outlined in this summary of your Board's activities over the past year and the reports of

the FMA councils and committees included in the Delegates' Handbook reflect the continued pursuits of organized medicine in providing quality care to the citizens of our State and preservation of the high standards and ethics of our profession in the face of great adversities.

We have been concerned that the welfare of our patients may be jeopardized and the application of the advances in medical science threatened because of the malpractice crisis.

The incessant interference and schemes to seize control of our practices and our personal lives by government continues unabated. Social and health planners are proceeding to develop master plans that would make health care delivery little more than a public utility.

We, as physicians, know without question that our system of medical care is the finest in the world. Conversely, we are first to recognize its imperfections and have worked to improve its shortcomings. We are dedicated to the betterment of the public health, the preservation of life, and we care about those whose illnesses we treat.

The destruction of our health care system will not improve the quality of health care—it will only result in further deterioration of the fiber of independence and self-reliance on which this Country was founded.

—Lest we falter and acquiesce to those who would destroy our self-reliance and our freedom to practice medicine with integrity, we will prevail against all adversity.

The single greatest asset this Association has is the physicians who give of their time and talents in activities of the Association, and your Board is grateful to each and every one.

Your Chairman is deeply honored for having had the opportunity of serving this fine organization and for the privilege of associating with those who served on the Board this year. Each one has represented his fellow physicians to the best of his ability and has given unselfishly of his time and talents. Your Chairman wishes to thank each of them: Vernon B. Astler, James Russell Forlaw, O. William Davenport, Richard S. Hodes, Norman M.



Reference Committee III heard discussion on most of the annual report of the Board of Governors and other matters related to Finance and Administration. Left to right: Joseph Harris, M.D., Miami Beach; Mrs. Sandy Neel, Jacksonville, Recorder; Committee Chairman Robert P. Johnson, M.D., Tallahassee; Harold A. Yount, M.D., West Palm Beach; Kay K. Hanley, M.D., Clearwater; and Franklin B. McKechnie, M.D., Orlando.

Kenyon, Theodore J. Marshall, Thad Moseley, Louis C. Murray, Donald G. Nikolaus, Thomas B. Thames, Joseph C. Von Thron, Robert E. Windom, Benjamin M. Cole, Charles J. Kahn, Joseph G. Matthews, Eugene G. Peek, Jr.

Your Chairman regrets the loss of Curtis W. Cannon, M.D. because of his untimely death on June 10, 1976.

Major Activities

Your Board has spent many hours in formal session in review of the activities of councils and committees and many other crucial matters of primary concern to medicine. The following is a summary of the major activities and actions of the Board in its deliberations and its recommendations to the House of Delegates.

1977 Annual Meeting—The Board approved the format for the 1977 Annual Meeting and noted with pleasure the continuing improvement in the quality of the scientific program and the promptness with which the program is prepared. Dr. J. Lee Dockery and Dr. O. Frank Agee (and the members of the Committee on Scientific Programs) were commended for their efforts in this regard.

1977 Called Meeting of the House of Delegates—The FMA House of Delegates met in a Called Meeting January 28-30 in Orlando to deliberate the Association's 1977 legislative program priorities and other business recommended by the Board of Governors. The House adopted the following legislative program to be introduced during the 1977 Session of the Legislature as "Priority '77":

- (1) Professional liability insurance legislation
 - A. Establishment of an absolute two-year statute of limitations.
 - B. Provision for recovery of defense costs in medical malpractice cases.
- (2) Legislation to create a separate Department of Health headed by an M.D. or Osteopath with Cabinet rank.

An FMA policy statement recommended by the Board of Governors and a resolution introduced by the Orange County Medical Society on mandatory professional liability insurance as a requirement for hospital staff privileges was adopted by the House at its Called Meeting. Recommendations for improvements in Florida's Medicaid Program were also adopted by the House.

The House of Delegates expressed its appreciation and commendations to the FMA Officers, Dr. James W. Walker, President of PIMCO, and FMA Executive Vice President, W. Harold Parham, D.H.A., for their efforts in establishing the FMA's professional liability insurance companies. Dr. Jack MacCris, FMA President, made an in-depth report to the House in Executive Session regarding the FMA insurance programs: FMA Professional Liability Insurance Trust, Florida Physicians Insurance Reciprocal, and Professional Insurance Management Company. This report included an explanation of the organization and finances of all three of these organizations.

The General Session on Saturday included an update by Dr. MacCris on priority items during the year. Areas covered were communications with members, the public relations program, coordination of legislative activities with county medical societies, active support of FLAMPAC, statewide health planning activities, establishment of a statewide peer review organization in the private sector, the emergency medical service program and continued efforts in the areas of physician availability and cost of medical care in nursing homes.

Presentations were also made by FMA council chairmen regarding the activities of their respective councils during the year.

The Called Meeting was preceded by a FLAMPAC legislative program that included a presentation on physician involvement in the political process and a panel discussion on working with your legislators. The conference was highlighted with a luncheon and address by Congressman Otis Pike (D-NY).

The complete proceedings of the Called Meeting of the House were printed in the March issue of the *FMA Journal*.

Financial Statement and Budget—The Board reviewed the financial statement prepared by the Executive Vice President and approved the auditors' statement presented by the Treasurer, prepared by Lucas, Herndon, Hyers, & Pennywitt, Certified Public Accountants. This audit report which covered the calendar year 1976, showed Association regular income from all sources was \$1,573,599.89 and total expenses during the year were \$1,253,882.06. This was an excess of \$319,717.83 in income over expenditures. These figures do not include funds expended for equipment purchased for the FMA headquarters building or the Capital Office totaling \$110,123.23, nor interest paid and other expenses as these are carried under the fixed assets of the Association. The actual net gain to the Association during 1976 was \$62,177.42. The Board approved a budget for 1977 totaling \$1,332,000.00 which is anticipated income from all sources. This reflects a 0-anticipated increase in income during 1977. In compliance with the Bylaws, the budget was prepared by the Executive Vice President in consultation with the Treasurer.

FMA Special Assessment—Funds received from the 1976 FMA special assessment approved by the House of Delegates at its meeting February 1, 1976, were earmarked by the House for legislative and public relations activities. These funds have been maintained in an account separate from the regular income and expenditures of the Association. At preparation of this report, funds received through the assessment have totaled \$872,400.00. There has been an additional \$20,872.25 earned from interest received from funds placed in savings until needed. During 1976, total expenditures were \$248,028.56 and to date in 1977, \$159,382.13 has been expended. These expenditures include production and showing of the FMA television special, "A Matter of Life," and also the 1976 Professional Liability Legislative Program. This leaves a balance of \$485,861.56 in the assessment fund.

As a result of the recent ruling of a Leon circuit court declaring the entire 1976 professional liability legislation enacted by the legislature unconstitutional and plans for production of another television film in late May, it is anticipated that the remaining funds in the assessment fund will be greatly depleted during the coming months.

Headquarters Building and Capital Office—The Board of Governors approved purchase of the Commercial Union building located approximately 1/2 block from the FMA headquarters office on Riverside Avenue. The two-story red brick structure contains 30,000 square feet and will house the FMA staff and allow for future growth. Approximately 10,000 feet will be occupied by PIMCO, the management company established by FMA to administer the Association's Professional Liability Insurance Reciprocal. It is expected that the payment of the \$990,000.00 purchase price will be made largely through sale of the FMA headquarters building and the May Street property. Any remaining mortgage will be paid from income received from lease of office space to PIMCO.

The FMA Capital Office purchased in 1975 was renovated and occupied by the Capital Office staff in early June 1976. The single story building contains approximately 3,000 square feet of office space and is strategically located just one block from the Capitol. This \$120,000.00 expenditure was paid for by FMA's interest in Harlan-Med, Inc.'s liquidation distribution and not from Association reserves.

Appointments—The Board of Governors approve the nomination of Joseph C. Von Thron, M.D. as the AMA Delegate to serve on the Board of Governors. Thomas B. Thames, M.D., Orlando, was appointed as optional member of the Executive Committee.

Appointed as advisory members of the Board of Governors were Eugene G. Peek Jr., M.D., Department of Health and Rehabilitative Services; Joseph G. Matthews, M.D., Blue Shield of Florida, Inc.; Benjamin M. Cole, M.D., Florida State Board of Medical Examiners; and Charles J. Kahn, M.D., Speaker of the House of Delegates. Vernon B. Astler, M.D. was designated as Public Relations Officer and Joseph C. Von Thron, M.D. was designated as the Board's representative to FLAMPAC.

REFERENCE COMMITTEE NO. III

Gerold L. Schiebler, M.D., was reappointed to serve as Editor of the *Journal of the Florida Medical Association* for 1977-78. William M. Straight, M.D. was appointed FMA Historian and Historical Editor of the *Journal* and Theodore J. Marshall, M.D. was designated as the Board of Governors' representative on the Scientific Publications Committee.

Appointed as Chairmen of Committees of the Board were:

Committee on Allied Health Professions

Luis M. Perez, M.D.

Committee on Voluntary Health Agencies

Robert C. Palmer, Jr., M.D.

Committee on County Medical Society Presidents

John M. Hamilton, M.D.

Appointed as Chairmen of Special Committees were:

Committee on Nursing Homes

Donald G. Nikolaus, M.D.

Committee on Sports Injuries

Bernard Kimmel, M.D.

Committee on Cost of Medical Care

James F. Richards, M.D.

Committee on Long-Range Malpractice Planning

William J. Dean, M.D.

James T. Cook, M.D. and Burns A. Dobbins, Jr., M.D. were elected Chairman and Vice-Chairman respectively of the FMA Delegates to the American Medical Association.

Awards

A. H. Robins Award—The Board reviewed nominations received from county medical societies and selected the recipient of the A. H. Robins Company Award "For Outstanding Community Service by a Physician." This award will be presented at the First Meeting of the House of Delegates on May 4, 1977. The recipient for this year's award is included in the Delegates' Packets.

Distinguished Layman's Award—The House of Delegates in 1972 established a Distinguished Layman's Award. The purpose of the award is to recognize individuals who have made significant and lasting contributions to the medical profession. The House directed the Board to develop the criteria for establishing the award and further that the Board would select the recipient.

The Board has selected State Senator Thomas M. Gallen of Bradenton as the 1977 recipient of the Distinguished Layman's Award. The appropriate citation, along with criteria, is included in the Delegates' Packets for information.

Nominations

Certificate of Merit & Certificate of Appreciation—The Board did not place in nomination to the House of Delegates a physician to receive the Certificate of Merit for 1977 (the Association's highest honor of achievement). The Board has nominated two outstanding physicians to receive the 1977 Certificate of Appreciation. These nominations are included in the Delegates' Packets for presentation at the First Meeting of the House of Delegates.

Judicial Council—In compliance with the FMA Bylaws, the Board of Governors has considered nominations for terms expiring on the Judicial Council in 1977. The Board nominates Joseph H. Davis, M.D., Miami, to the House of Delegates for election to the Judicial Council at-large for a five-year term.

Committee on Membership and Discipline—In compliance with the Bylaws, the Board has reviewed terms expiring in 1977 on the Committee on Membership and Discipline. Nominations from county medical societies have been considered and the Board nominates the following physicians for election to the Committee on Membership and Discipline for the terms indicated:

District 1

Herbert E. Brooks, M.D. (81)

District 2

James K. Conn, M.D. (81)

District 3

Joe C. Ebbinghouse, M.D. (81)

District 4

Samuel L. Renfroe, M.D. (81)

District 5

Luis M. Perez, M.D. (81)

District 6

Royce V. Hobby, M.D. (81)

District 7

Jeff W. Harris, M.D. (81)

District 8

James D. Morgan, M.D. (81)

District 9

Lee Rogers, M.D. (81)

District 10

Martin Mihm, M.D. (81)

District 11

Reginald J. Stambaugh, M.D. (81)

Charles E. Metzger, M.D. (78)

District 12

Robert L. Brennan, M.D. (81)

District 13

Maurice Laszlo, M.D. (81)

District 14

Richard M. Fleming, M.D. (81)

District 15

John D. White, M.D. (81)

Blue Shield Board of Directors—The Board selected nominees for election to the Blue Shield Board of Directors from a list of names submitted by the Blue Shield Nominating Committee. Nominees for each physician seat were selected as follows:

Medical District A—One Vacancy—Three Year Term

Charles P. Hayes, M.D., Jacksonville

Jack MacDonald, M.D., Tallahassee

Medical District C—One Vacancy—Three Year Term

Joseph G. Matthews, M.D., Orlando

C. Robert Cambron, M.D., Ft. Pierce

Medical District D—One Vacancy—Three Year Term

Richard C. Clay, M.D., Miami

Stanley I. Holzberg, M.D., Miami

At-Large—One Vacancy—Three Year Term

Frank B. Hodnette, M.D., Pensacola

John Fletcher, M.D., Tampa

Lay members nominated by the Nominating Committee and approved by the Board are:

Medical District C

William V. Roy, Orlando

At-Large—One Vacancy—Three Year Term

Hazel Sulzbacher, Jacksonville

Hospital Administrator/Blue Cross Board Member—One Vacancy—One Year Term

Robert T. Besserer, Sanford

Florida State Board of Medical Examiners—In compliance with the House of Delegates' policy, the Board of Governors taking into consideration recommendations by component medical societies, compiled a list of physicians which was forwarded to Governor Reubin Askew for his consideration in making appointments to the Florida State Board of Medical Examiners.

AMA Councils and Committees—The Board was pleased to submit nominations of Florida physicians for appointment or reappointment to AMA councils and committees.

Referrals by House of Delegates

The 1976 Proceedings of the House of Delegates were reviewed and items requiring additional study and action were referred to the appropriate councils and committees. Some matters required Board action only. Individual actions regarding the policies of the House of Delegates appear in the various council reports as well as in this report.

Pap Smears—The House of Delegates referred the Board's recommendation regarding payment for pap smears by all government medical care programs and third parties back to the Board for specific recommendations.

The determination of pap smears as a necessary medical procedure has been recommended on frequent occasions with the request that physicians be reimbursed for this procedure by all government medical care programs and third party carriers. This position was reiterated by the Board at its 1976 post-convention meeting.

The Board was advised by the Council on Specialty Medicine that Blue Shield would not approve payment for pap smears if they are routine and not for diagnostic purposes.

Recommendation No. 1

(Referred back to the Board of Governors—R.C.I.)

That the FMA continue to encourage all government medical care programs and third parties, including Blue Shield, to consider pap smears as a necessary procedure and provide reimbursement to physicians for this procedure.

Resolution Re Social Security Numbers—The House of Delegates approved support of the resolution submitted by the California Medical Society regarding social security numbers and directed that this resolution be sent to all state medical associations and that FMA delegates to the AMA be requested to support its adoption in the AMA House of Delegates.

This resolution resolved that the FMA express its total opposition to the use of the social security number as a universal identifier and encourage all medical societies, all hospitals and other providers of medical care to oppose the use of the social security number as a universal number identifier.

This resolution was considered by the AMA's House of Delegates at its Annual Meeting in June, 1976. The House passed an amended resolution that any universal identifying number should not be placed on patient charts.

Death with Dignity—The Board of Governors recommended to the House of Delegates at its 1976 meeting that FMA reaffirm the position adopted by the House of Delegates in 1974 that medical matters as the criteria of or the time of death or what constitutes death with dignity are the physicians responsibility requiring professional judgement and should not be the subject of legislation. This recommendation was not approved but referred back to the Board for further study.

FMA Legal Counsel was requested to research the Florida law as to the legal definition of death.

Recommendation No. 2

That the House of Delegates approve in principle the following statement regarding a legal definition of death:

"It appears that Florida law has not undertaken to define death except as to fetal death, but has by implication left such determination to the physician based on the prevailing medical standard and the facts of the specific case."

and further:

"That medical matters as the criteria of death or the time of death or what constitutes death with dignity are the physician's responsibility requiring professional judgment and should not be the subject of legislation and for these reasons, the FMA opposes "death with dignity legislation".

1975 RVS Reduced Anesthesia Value for Supervision — The House of Delegates referred the Board's report to the House on the 1975 RVS back to the Board of Governors for reconsideration of Section 48, page 43, "Reduced Anesthesia Value of Supervision", for possible deletion or to be rewritten. This was referred to the Committee on RVS for consideration and recommendations. In making its recommendation to the Board, the Committee pointed out that the basic philosophy of the RVS was to include only descriptors for professional services rendered by physicians.

Recommendation No. 3

That Modifier -48 in the 1975 Florida Relative Value Studies be amended to state: "When the anesthesiologist is supervising the services of the nurse anesthetist who is not in the employ of the supervising anesthesiologist and is involved in medical direction of the patient, including pre- and post-operative evaluation and care, but is not personally administering the anesthesia, his reimbursement shall be for the basic value of the procedures plus one unit per hour or fraction thereof, for the duration of the anesthesia. The anesthesiologist shall remain within visual and auditory range of the operating rooms under medical direction and shall extend medical direction to no more than two rooms. Medical direction excludes simultaneous administration of anesthesia by the anesthesiologist". (Approved—R.C. V)

Resolution 76-12, Hospital Requirement of M.D. Insurance and Resolution 76-22, Mandatory Malpractice Insurance Coverage—The House of Delegates referred to the Board for study Resolution 76-12 introduced by Everett Shocket, M.D., Delegate, and Resolution 76-22, Volusia County Medical Society, regarding the requirement of mandatory professional liability insurance as a requirement of hospital staff privileges. The Board of Governors, after considering the concepts embodied in these resolutions and a resolution submitted by the Orange County Medical Society, recommended to the House of Delegates at its Called Meeting January 28-30 adoption of a policy statement on mandatory insurance. The House approved this statement and also Resolution 77-CM-1, Professional Liability, Orange County Medical Society. The complete text of the policy statement and the Orange County resolution was included in the proceedings of the House printed in the March issue of the **FMA Journal**. (R.C. V)

Resolution 76-20, Professional Standards Review Organization—This resolution was not adopted by the House. The resolve of this resolution provided that any county medical society that so desires be allowed to undertake the development of a PSRO without the requirement of signatures of 50% of its membership and under the same rules and regulations that any other group is required to undertake in such a development.

In considering the reference committee's report regarding this resolution, the House referred that portion of the reference committee's report to the Board of Governors requesting an opinion from the Speaker of the House and Chairman of the Judicial Council as to whether the 50 percent approved mandate in Resolution 74-CM-1 specifically relates only to component county medical societies of the FMA. The Board of Governors reviewed recommendations regarding this resolution at its Fall Meeting.

RECOMMENDATION NO. 4

That Resolution 76-20, Professional Standards Review Organization, not be adopted, and that FMA reaffirm the policy previously adopted by the House of Delegates at its called meeting in 1974:

"Resolved, that no FMA component medical society may form a PSRO or actively participate in the formation of a PSRO in their respective area unless they have first taken a poll of their membership and have received more than 50% approval of the active and life membership of the County Medical Society for that participation, and be it further

"Resolved, that any individual physician may participate fully in PSRO, but the Florida Medical Association reaffirms its encouragement to its membership to exercise their option to participate or not to participate in PSRO.

Resolution 76-27, Relative Value Studies—This resolution was not adopted but referred to the Board of Governors. The resolve of this resolution recommended that further studies or references to Florida Medical Association Relative Value Studies, except where currently required by law, cease.

The Board of Governors has considered the current investigation of the Federal Trade Commission into the use of relative value studies by a number of specialty societies and state medical associations.

RECOMMENDATION NO. 5

That Resolution 76-27, Relative Value Studies, referred to the Board of Governors by the 1976 House of Delegates, be disapproved. (Approved—R.C. V)

BOARD ACTIONS OF MAJOR IMPORTANCE

The Board adopted the following FMA program priorities for 1976-77 and directed that all available financial and staff resources be utilized in carrying out these programs:

1. Special emphasis on liaison with county medical societies and the development of new, more effective communications with the FMA membership.
2. In-depth implementation of a comprehensive statewide public relations program.
3. Continued emphasis on coordination of legislative activities with the county medical societies.
4. Continued active support of FLAMPAC.
5. Statewide health planning activities.
 - A. Emphasis on liaison with the Department of Health and Rehabilitative Services.
 - B. Continued encouragement of county medical societies to insure physician participation in the development of HSA's.
 - C. Representation on and input in the State Health Coordinating Council.
 - D. Development of adequate safeguards in the collection and utilization of health data and the protection of the confidentiality of such information.
6. Continued efforts to establish a statewide peer review organization in the private sector to conduct current review programs and also to serve as a

data support center.

7. Emergency services—emergency medical services.
 - A. Establishment of a statewide emergency medical services network.
 - B. Establishment of standards for optimal critical care facilities.
 - C. Active support of CPR Life Support Training Programs.
8. Continued efforts in the areas of physician availability, cost of medical care and nursing homes.

The accomplishments achieved to date in these priority programs are reflected in large part in the individual annual reports of FMA councils and committees included in the Delegates' Handbook. The following is a brief summary of some achievements in these major areas of activity.

The actions of the House of Delegates at its Interim Meeting in January, 1976, generated a significant acceleration in the level of Association activities, particularly, in the FMA legislative program and public relations.

There is no question but that the comprehensive PLI legislative package introduced during the 1976 legislative session was a monumental undertaking. The hundreds of hours spent by FMA Officers and individual members is inestimable. The results were without question a measurable success. The professional manner in which this program was carried out has drawn commendation from many legislators including the leadership.

An enormous amount of time and effort has gone into the development of the Florida Physicians Insurance Reciprocal. This is undoubtedly an extraordinary accomplishment in behalf of the physicians of Florida.

In juxtaposition with the legislative effort has been the development of a statewide comprehensive public relations program. Many of the accomplishments in this area of activity are included in Dr. Vernon B. Astler, Public Relations Officer's, report to the House which is included in the Delegates' Handbook. In general, however, the FMA has made much progress in laying the foundation for an effective long-range program.

Concentrated efforts have been made to create an atmosphere of cooperation with key House and Senate legislative committees concerned with developing legislation in the areas of cost containment and physician availability. There appears to be growing understanding and trust which hopefully will result in legislation that will not be detrimental to the practice of medicine.

FMA has responded positively to questions raised by House and Senate Committees of the Florida Legislature regarding actions that physicians are taking to curtail the spiraling cost of medical care, and also to help solve problems with Florida's Medicaid Program.

The FMA established a Committee on the Cost of Medical Care composed of a cross section of health care professionals to study ways of curtailing rising health care costs. This Committee has determined a number of positive actions that are currently being implemented to help solve this problem including pilot projects in various hospitals and physician educational programs.

FMA physician representatives have spent countless hours on advisory committees and testifying before legislative committees in an effort to find solutions to problems in Florida's Medicaid Program. Comprehensive and positive recommendations have been made by FMA to help solve the many problems in the Medicaid Program.

There have been concentrated efforts to develop more effective input into the medical service programs of the Department of HRS. While there has been much friendly dialogue, no concrete advances have been made. The continuing deterioration of the identity of health services in the Department, the lack of physician input, and the ominous effects of Public Law 93-641, "National Health Planning Act", are a continuing concern.

There have been continuing efforts to implement a contract between the Florida Medical Foundation and the

Department of HRS for medical peer review of Florida's Medicaid Program.

The EMS Conference sponsored by the Florida Medical Foundation for establishing standards for critical care facilities is the first such Conference held in the nation and has been widely applauded. Emanating from this Conference will be standards of emergency medical care that will be beneficial to all Floridians. FMA has also exerted great effort to ensure proper training and supervision of EMS personnel (EMT 1/II Paramedics).

A major accomplishment has been the bringing to fruition of the Florida Health Data Corporation. This cooperative effort between the FMA, Florida Hospital Association, and the Florida Osteopathic Medical Association is a significant step toward insuring the proper use of medical care data and protection of its confidentiality.

The approval of the Board to purchase badly needed equipment for the headquarters office has greatly assisted in the dissemination of information to the membership. The professionalism of FMA communications has been enhanced and, moreover, the efficiency of many administrative functions have been greatly improved.

There will be continued emphasis in these program priorities through:

- Special emphasis on liaison with county medical societies.
- Further implementation of a statewide public relations program.
- Emphasis on coordination of legislative activities with county medical societies.
- Active support of FLAMPAC.
- Close monitoring of statewide health planning activities. During the coming year the health planning activities throughout the state will be of major importance and will require close monitoring by FMA. County medical societies and individual physicians must exert as much influence as possible on planning activities at the local level if further infringements on the private practice of medicine are to be averted.
- Continued efforts to establish a statewide peer review organization in the private sector.
- Further development of statewide emergency medical services.
- Continued efforts in the areas of physician availability, cost of medical care and nursing homes.

1. **FMIT Program** — The Board approved a contract entered into by the Florida Medical Insurance Trust with Blue Cross-Blue Shield of Florida to continue as insurance carrier for the FMIT Program.

2. **Council and Committee Functions and Procedures** — The Board established policies for functions and procedures of FMA councils and committees including budget policies.

3. **House of Delegates Ratio** — The Board approved a recommendation that the current ratio used in determining membership of the House of Delegates of one delegate for each forty active members be maintained for another year.

4. **1979 Annual Meeting** — The Board of Governors voted to hold the 1979 FMA Annual Meeting at Lake Buena Vista, Florida subject to satisfactory arrangements being made.

5. **PL 93-641 (Health Planning)** — The Board of Governors has shared the grave concern expressed by FMA councils and committees regarding the implementation of PL 93-641, the National Health Planning and Resource Development Act. This legislation poses an ominous threat to the practice of medicine and delivery of quality medical care.

As reported earlier, this continues to be a major priority of the Association. Many physicians have given countless hours of their time in seeking to insure some degree of physician input in the health planning process

which will have such sweeping effects on the delivery of health care in Florida. FMA has nominated numerous qualified physicians to serve on HSA district advisory councils and also the State Health Coordinating Council. FMA has vigorously opposed full designation of the Department of HRS as the State Health Planning and Development Agency under PL 93-641 and reaffirmed the previous decision of the House of Delegates to proceed with development of a PRO program working within the private sector.

6. **Francis T. Holland, M.D.** — The Board expressed appreciation to Francis T. Holland, M.D., Tallahassee, for his many years of service to the FMA as chairman of Florida's Delegation to the AMA. Dr. Holland's term as AMA delegate expired December 31, 1976, and he did not seek reelection. He has served as a delegate for 22 years. Dr. Holland was elected Vice President of AMA at its annual meeting in July.

7. **Donn L. Smith, M.D.** — The Board of Governors commended Dr. Donn Smith for his outstanding work as Dean of the University of South Florida, School of Medicine and wished him success in his future endeavors upon stepping down from his post.

8. **State Board of Medical Examiners** — The Board expressed support for the Board of Medical Examiners in its effort to gain additional budgetary increases for administrative staff.

9. **FMA Directory** — The 1977 Florida Medical Directory, released in March, 1977, includes an expansion of the section on FMA recognized voluntary health agencies. This was an attempt to better inform physicians and the public as to the services and programs available through these organizations.

10. **Generic Drug Law** — The Board directed that the FMA not institute legal action to set aside Florida's generic drug law as requested by the Pharmaceutical Manufacturers Association, but suggest that the PMA may wish to institute suit through a single individual and that FMA provide appropriate technical assistance only.

11. **Cut-Rate Medical Testing Centers** — The Board has reviewed with much concern the proliferation of cut-rate medical testing centers throughout the State of Florida. It was pointed out that the FMA position regarding lay laboratories did not adequately address the present situation. The Health Program Office has been requested to include regulations for circulation of schedules of services and fees in the requirements for licensure for lay laboratories.

FMA Legal Counsel has been instructed to investigate possible legal recourse regarding cut-rate medical testing centers in Florida and that this be done in cooperation with the Attorney General.

12. **Hospital Staff Privileges for Non-Physicians** — The Board reviewed a policy statement on hospital staff privileges for non-physicians as proposed by Vernon B. Astler, M.D.

RECOMMENDATION NO. 6

That membership on the active medical staff is basically created for medical doctors and should be limited to competent and qualified physicians and surgeons and to certain dentists who meet the criteria of the medical staff bylaws.

That where the services of certain allied health professionals or semi-professionals are necessary within the hospital setting, they should be considered for some medical staff affiliation which would allow them to come in on the basis of a medical staff request or consultant, and further

That this staff category should carry no voting rights, no mandatory obligations or committee membership appointments and should certainly not encompass the privilege of the medical order sheet, and that any recommendations they have with regard to orders could be made in the consultation report and the requesting physician determine the feasibility of implementing these orders at his discretion, and further

That they carry no voting rights on the medical staff or in the various departmental meetings of the staff.

This will assure the availability of services of these health professionals to the patients as they are needed, but still maintain quality and not open doors to all manner of persons involved in the health delivery field. (Adopted R.C. II)

13. Insurance Fraud — The Board reviewed a request from the Florida Association of Insurance Companies that FMA participate in a program to encourage persons in Dade and Monroe counties to report instances of fraud primarily in the automobile area. FMA was asked to participate in establishment of a reward fund to create public visibility of efforts to combat this problem.

RECOMMENDATION NO. 7

That while the FMA condemns acts of fraud in any form and will continue to work with the State Board of Medical Examiners or any other legally constituted agency in investigations of fraud involving physicians, it is not within the purpose of the FMA to participate in the establishment of a public reward fund but that this should more properly be the responsibility of the appropriate law enforcement agency.

14. Mediation Panels — The Board concurred in the President's Memo sent by Dr. Jack MacCris to all FMA members outlining the importance of their participation in mediation panels to insure that the concept has a fair chance to work.

15. Key Contact Physicians—Approved the U.S. Congressional Key Contact Physician assignments for 1977.

16. Missouri State Medical Society Resolution Re Federal Licensure—The Board reviewed the resolution of the Missouri State Medical Society condemning legislation proposing Federal licensure of health manpower.

RECOMMENDATION NO. 8

That the Florida Medical Association support the resolution of the Missouri State Medical Association regarding federal licensure and that FMA's delegates to the AMA be requested to support adoption of the resolution by the AMA's House of Delegates:

"Whereas, we have recently received a pamphlet from the Missouri Division of Professional Registration in which attention is called to a proposal

for credentialing health manpower by the federal government, and

"Whereas, this essentially refers to licensure and re-licensure by the federal government, thereby taking away such authority from the States, and

"Whereas, this proposal is supposedly being initiated by the Department of Health, Education and Welfare, and

"Whereas, we object to the singling out of the medical profession for federal licensure and omitting all other professions, and

"Whereas, both the American Medical Association and the Missouri State Medical Association have already shown their approval of continuing medical education as the best solution for maintaining physicians' training, therefore be it

"Resolved, that the House of Delegates of the Missouri State Medical Association view this proposal for federal licensure with great alarm, and be it further

"Resolved, that the House of Delegates goes on record as opposing any legislation proposing federal licensure of health manpower, and be it further

"Resolved, that copies of this resolution be sent to the Director of the Department of Consumer Affairs, Regulation and Licensing; the Director of the Division of Professional Registration; the Board of Healing Arts; the Governor; Missouri's Congressmen and Senators; the American Medical Association and other State Medical Societies."

17. Professional Liability Insurance — The FMA submitted a comprehensive Professional Liability Legislative Program to the 1976 Session of the Florida Legislature. This program was a major effort to ease the malpractice crisis in Florida.

As a result of the individual and combined efforts of those physicians who actively supported the program, and the understanding members of the Florida Legislature, major provisions of our Professional Liability Legislative Program were enacted into law in 1975 and 1976. The subsequent support of these laws by physicians of the State combined with appropriate judicial interpretation has been a positive step toward stabilizing the professional liability crisis.

To complete this effort, it is deemed essential that two major provisions of the 1976 FMA Professional Liability Legislative Program, which have not been adequately addressed, be considered by the 1977 session of the Florida Legislature. Recognizing the need for additional legislation, the FMA House of Delegates at its Called Meeting January 28-30, 1977, in Orlando, adopted these two provisions as professional liability legislative priorities for 1977.

1. Establishment of an absolute two-year statute of limitations
2. Provision for recovery of defense costs in medical malpractice cases

Unfortunately, a circuit court ruled the law passed by the 1976 Legislature unconstitutional on February 28, 1977. It is essential that these laws be restored by the Florida Supreme Court (currently being appealed) or re-enacted by the 1977 Legislature combined with our two

proposals originally planned for the 1977 Legislative Session:

- Application of collateral sources in jury trials, as a direct offset.
- Definition of medical professional negligence.
- Definition of medical expert witnesses.
- Prohibit use of *res ipsa loquitur* doctrine in professional negligence actions.
- Structured pay-out of future damages (The Senate-House Conference Committee amended this provision for structured pay-outs only when damages exceed \$200,000).
- A Remittur-Additur provision which provides for the judge to lower or raise an award if, in his opinion, the jury verdict is excessive or inadequate. (R.C. IV)

18. **Constitutional Revision Commission** — The Board has nominated several physicians for appointment to the Constitutional Revision Commission being established for the purpose of considering proposed amendments to the Florida State Constitution.

19. **"AMA News"** — The Board expressed its complete concurrence with the sentiments expressed in the letter written by the FMA Executive Vice President to Dr. James H. Sammons, Executive Vice President of the AMA, regarding the inappropriateness of the article printed in the February 14 issue of the "AMA News" on the medical care situation in Key West, Florida.

It was noted that the article was based on hearsay and accusations and could only result in further tarnishing the image of the medical community. It would have been a much more timely and accurate story had it been published at some time after the investigations had been completed.

20. **Second Surgical Opinion Program** — The Board of Governors discussed at great length the Second Surgical Opinion Program to be implemented in a seven county area in Florida by Travelers Insurance Company and General Telephone.

RECOMMENDATION NO. 9

That the Florida Medical Association adopt the following policy with regard to second surgical opinions:

"FMA believes each patient has a right to consult any physician of his choice. FMA believes each physician should give a patient his opinion concerning the patient's needs. FMA believes the principles of medical ethics already requires second opinion when the patient or the attending physician believes this to be indicated. FMA believes the intrusion of a third party into this relationship by insisting upon a second surgical opinion prior to elective surgery increases the cost of medical care and will not improve the quality of care which the citizens of Florida are now receiving."

21. **FMA Special Assessment** — Made a ruling that physicians joining the Association on or after October 1, 1976, be assessed 50% of the full assessment.

FMA Councils and Committees

The Delegates' Handbook will reflect the many hours of work that have gone into the activities of the Association's councils and committees. Many physicians have given freely of their time and your Board is grateful for their dedication and interest in improving the quality and quantity of health care for the citizens of Florida. The

following is a summary of the Board's actions regarding the recommendations of councils and committees. A complete review of their activities over the past year is included in this Handbook.

Judicial Council

Telephone Directory Yellow Page Listings — At the January 1976 meeting of the House of Delegates, the House amended the FMA's previous policy governing listing in telephone directories. The specific amendment allows members of the FMA to list, in addition to the regular alphabetical yellow page listing, only under those specialties that have certifying boards and which boards are approved by the AMA and in which the physician is Board certified or eligible or which he limits his practice to.

Southern Bell has indicated full support in abiding by the FMA approved specialty listings for telephone directory yellow page advertising as approved by the House of Delegates. However, there have been some delays in bringing all telephone directories into compliance with the new policy because some phone books had already been released for printing prior to the actions of the House.

At its March meeting, the Board received a report from representatives of the Florida Society of Otolaryngology regarding problems which have been created as a result of the current requirements. It was reported that a number of malpractice claims have involved the use of the criteria for yellow page listings in determining the qualification of a physician to practice a particular specialty. It was requested that the Board change present policy or issue a statement to the effect that the fact that a physician is or is not listed under a specific specialty is in no way determination of the physician's ability to practice in that specialty.

After much discussion of this matter and with the concurrence of Dr. William Thompson, Chairman of the Judicial Council, the Board approved a statement regarding the Association's yellow page listing requirement —

"The FMA policy governing listing of members in telephone directories established basic ethical and professional standards for members who list in the yellow and white pages of the telephone directories. Additionally, it is the function of this policy to provide members of the public basic information in selecting a physician. However, this policy and the fact that a physician may or may not be listed under a specific specialty heading in no way reflects FMA endorsement or rejection of an individual physician's qualifications and/or training to practice within a particular specialty."

The Board pointed out that it could not change House policy and that the Florida Society of Otolaryngology should request any changes in the current policy on telephone directory yellow page listings through submission of a resolution to the House of Delegates.

Osteopathic Membership — The Board was advised that as a result of the House of Delegates' action in adopting amendments to the FMA Bylaws opening membership in the FMA and component county medical societies to osteopaths who have completed an AMA approved internship or residency program, it appears that county medical societies chartered by FMA must make corresponding changes in their bylaws so as not to be in conflict with those of the FMA.

The Judicial Council was requested to advise component county medical societies as to the necessary amendments required to be made in their bylaws to provide for membership in the county medical society for qualified osteopaths.

Council on Legislation and Regulation (R.C. IV)

Florida Academy of Trial Lawyers — The Board of Governors is aware that considerable activity is anticipated from the Florida Academy of Trial Lawyers in trying to repeal some of the legislation passed in the area of mal-

practice; and that in order to successfully combat such efforts, substantial time of Association staff and physicians will be needed; and further, that in adopting other Association legislative objectives, cognizance should be taken of the time likely to be devoted to this defensive battle.

Procedures to be Followed by Specialty Groups in Developing Legislative Objectives—The Board is aware that much time has been devoted to determining the most effective way to coordinate the legislative efforts of the FMA with those of related specialty groups so that maximum effectiveness for the Association's program and those of the individual specialty groups can be realized. It is felt that the guidelines adopted by the Council on Specialty Medicine dated September 19, 1974, should be followed by the Association as well as specialty groups if effective coordination is to be achieved. The Association's stated legislative objectives which are proposed to the legislature should include the more important ones advocated by the individual specialty groups.

1977 Florida Legislative Session—The Board has reviewed a number of bills to be introduced in the 1977 Session of the Florida Legislature which are of concern to medicine. The following is a summary of the positions taken with regard to these proposed bills:

State Board of Medical Examiners:

Approved support for budgetary increases that have been requested by the Board of Medical Examiners for additional administrative staff support.

Geriatric Outpatient Clinics:

The Board adopted a position of opposition to legislation which would create geriatric outpatient nurse clinics in conjunction with nursing homes. The bill requires these clinics to be managed and supervised by a geriatric nurse practitioner.

Consumer Advocacy:

Expressed opposition to legislation that would set up a Division of Consumer Advocacy within the Department of Community Affairs with duties to include "assessment of the effectiveness of medical services currently available to the people of Florida."

Deputy Assistant Secretary for Health Planning:

The Board adopted a position of opposition to legislation creating functions for Deputy Assistant Secretary for State Health Planning and Development including a state health information system.

The Board expressed strong opposition to proposed legislation which endorses the Kennedy-Corman concept for National Health Insurance.

The Board adopted a position to oppose several legislative proposals regarding chiropractic which would:

- Create an amendment to Workmen's Compensation law to allow patient choice of physician.
- Determine that a chiropractor shall be qualified as an expert witness within his area of licensure.
- Prohibit insurance companies from using M.D. testimony to demonstrate that a chiropractor's services were unnecessary.
- Allow chiropractor to certify disability for purposes of property tax exemption.
- Allow chiropractor to certify teacher is free from malignant, communicable or mental diseases.
- Require state employees group to provide chiropractic services (HB 146).
- Require all health insurance contracts to provide chiropractic services (HB 376).

The Board approved a position of support for legislation that requires use of standard health claim forms by all insurers and the Department of HRS.

The Board adopted a position to endorse legislation regulating diagnostic medical testing centers in the State of Florida.

Certificate of Need—The Board has expressed grave concern and opposition to proposed Certificate of Need legislation. This legislation is an intrusion into the private practice of medicine which can only result in an adverse

effect on the quality of medical care by state interference with a physician's ability to determine the scope of his practice within his own office.

Medicaid—Approved allocation of prime staff time to try to improve Florida's Medicaid Programs to include adequate funding, PMUR as a quality and cost control mechanism, orientation as a medical program with high visibility in the department, and to seek different means to deliver services to indigents through medical foundations and county medical societies.

Nuclear Medical Technologists—The Board referred the matter of certification of nuclear medical technologists to the Council on Specialty Medicine for resolution by that Council in anticipation of the possibility that the matter can be handled without the necessity for legislative action.

National Health Insurance—That the Florida Medical Association House of Delegates support the AMA's Bill on National Health Insurance.

Specialty Group Letter Agreements—The Board of Governors acknowledged the active negotiations being carried out with various specialty groups with regard to their entering into a letter of agreement with the Florida Medical Association for provision of legislative services; and that as of this date, a tentative commitment has been received from the Florida Society of Anesthesiology and the Florida Society of Ophthalmology to enter such a letter of agreement.

Council on Medical Economics (R.C. V)

The Board of Governors wishes to express its appreciation to Dr. James F. Richards, Jr. for his diligent efforts in behalf of Florida physicians to bring about equitable reimbursement schedules for physician services provided to all HRS medical service programs. The Board also commended those physicians serving on the RVS Committee for their hard work in development of the 1975 Florida Relative Value Studies.

DHRS Maximum Medical Compensation Schedule—The FMA has participated in a task force established by DHRS to study the department's reimbursement schedule for medical services. Recommendations were submitted to the Secretary:

That the present fee schedule payment level be increased to the 60th percentile on January 1, 1977.

That the fee schedule be increased to the 75th percentile on July 1, 1977 with the increase not to exceed 100 percent of the current fee schedule as of July 1, 1976.

That a standing Department committee containing medical professional members be appointed to aid the office of financial management in establishing and maintaining maximum compensation levels for procedures listed "By Report" in the 1975 RVS.

That the DHRS Medical Maximum Compensation Schedule be updated annually.

That a Medicaid management information system which includes peer medical utilization review under the Medicaid Program be implemented.

That medical service providers be involved in medical service policy making.

That in-house medical direction to the Medicaid program and direct input at the decision making level of this program be provided.

That the communication of DHRS policies, programs, and procedures to medical providers be provided.

Workmen's Compensation—A combined committee of the Florida Medical Association and The Florida Bar, consisting of three attorneys and three physicians was ap-

pointed by the Florida Medical Association Board of Governors to consider mutual problems involving Workmen's Compensation. The activities of this joint committee are included in the annual report of the Council on Medical Economics in the Delegates' Handbook.

Committee on Cost of Medical Care—The Board endorsed a joint pilot program of the Blue Shield Committee on Cost Containment and the FMA Committee on the Cost of Medical Care to monitor at Jacksonville Memorial Hospital, the impact of providing daily cumulative patient hospitalization charges to each attending physician on the medical staff.

The Board directed that the FMA request each hospital medical staff to review its hospital's routine admission orders to insure that duplication and unnecessary tests are not performed. The Board further recommended that each hospital medical staff develop a policy for running orders establishing limits on appropriate frequency and duration requiring the physician to reorder the services as it is medically necessary.

The Board supported the concept of the Duval County Foundation for Medical Care to develop an outpatient peer utilization review program.

The Board approved the concept of the Florida Medical Foundation through the Committee on Peer Medical Utilization Review instituting a traveling peer review team to carry out review of hospitals and physicians in hospitals not taking appropriate steps to contain costs who are identified by the Blue Cross "Unit Cost Program."

Council on Medical Systems (R.C. V)

Confidentiality of Health Care Information—The Board of Governors requested FMA's Legal Counsel to research the Florida Statutes as they pertain to confidentiality of health care information and draft an appropriate bill to protect the physician-patient relationship for consideration by the next Session of the Florida Legislature.

Data Broker Concept—The Board of Governors was apprised of the efforts on the part of DHEW to consolidate the various data gathering programs related to health and welfare. This activity under normal supervision of the National Committee for Vital and Health Statistics is not reported to the National PSR Council, nor is it otherwise subject to review and comment by the medical profession. It is apparent that the DHEW "Data Broker" concept is being promoted in the individual states and encouraged by promises of future federal funding for such efforts.

Medicaid Management Information System—The Board was informed of plans underway for the Department of HRS to implement a Medicaid Management Information System (MMIS).

Florida Health Data Corporation—The Board of Governors received a report on efforts to establish a health data consortium in the private sector. On September 11, 1976, the Council on Medical Systems met with representatives of the Florida Hospital Association, Inc., Florida Osteopathic Medical Association, Inc. and the Florida League of Hospitals for the purpose of assessing the desire on the part of all concerned to establish such a consortium. It was the unanimous vote of this body to work toward the establishment of a Florida Health Data Corporation, Inc. with the primary objective to establish and operate an independent health data bank which is accurate and completely comprehensive and controlled by the private sector.

The Board received a request for clarification of the role of the physician members of the Board of Directors of the Florida Health Data Corporation, Inc., as it pertains to PSRO. The Board authorized the physician members of the Board of Directors of FHDC to proceed with the negotiations of all necessary contracts, to be reviewed first by the Board before implementation.

PMUR-CHAMPUS Program—The Board was advised of the plans of CHAMPUS to have individuals other than physicians doing medical peer review for psychiatric benefits under the CHAMPUS Program.

RECOMMENDATION NO. 10

That the Florida Medical Association support Blue Shield's protest to CHAMPUS regarding individuals other than physicians performing medical peer review for psychiatric benefits under the CHAMPUS program. The FMA further reiterates the position of organized medicine that peer medical utilization review of physicians should only be performed by physicians.

Peer Review—The Board approved development of packages of information to distribute to county medical societies which explains in detail the peer review process.

PMUR Case Review—The Board expressed concern regarding cases referred to county medical societies for peer review that are not being reviewed by societies within time limits established in the PMUR Operating Procedures. Also, many health insurance cases are not being reviewed by the county medical societies within the time limits established by the Health Insurance Operating Procedures. The Board authorized the Committee on Peer Medical Utilization Review to take direct action and assume jurisdiction on cases not acted upon by the county medical societies within the time limits established by the Peer Medical Utilization Review Operating Procedures and the Health Insurance Operating Procedures.

Council on Medical Services (Amended—R.C. II)

County Health Departments—The Board expressed continued support for a substantial increase in state funding for county health departments.

Scoliosis Screening—The Board recommended to the Department of Health and Rehabilitative Services that screening for scoliosis be incorporated as part of a school screening program.

Council on Medical Services—The Board commended the Council on Medical Services and its committees for outstanding work in areas of major importance to the Association:

The Committee on Drug Abuse chaired by Dr. Robert P. Johnson, of Tallahassee, recently concluded an onsite evaluation of medical care in the state's 29 residential drug abuse treatment centers. This was done through a contract with the Department of HRS, Bureau of Drug Abuse.

The Committee on Emergency Medical Services chaired by Dr. Arthur L. Trask, of Boynton Beach, recently concluded a successful Conference on the Identification of Needs and Standards for In-Hospital Critical Care. This Conference was sponsored by the Florida Medical Foundation through a grant from the Emergency Medical Services Section of the Health Program Office.

Duplication of Restaurant Health Inspections—The Board of Governors approved in principle legislation which would require that inspections of food service establishments be conducted only under supervision of the State Health Agency and its component county health departments and that the present duplication of these inspections by the Division of Hotels and Restaurants of the Department of Business Regulations be eliminated.

CME Course—Advanced Life-Support Training—The Board approved establishment, through the Committee on Emergency Medical Services and Emergency Communications, of a CME course on advanced life-support training with each course being approved as hour-for-hour mandatory category credit for continuing medical education and urged each component county medical society to sponsor such a course on a recurring and timely schedule and

encourage their members to take advantage of such training.

Hospital Survey—The Board of Governors authorized the Committee on Emergency Medical Services to work with the Florida Hospital Association and Department of HRS for performing a joint survey on the critical care capabilities of Florida's hospitals.

State Disaster Plan—A review of the state disaster plan indicated that each county is responsible for its own disaster plan. Presently, these county plans are not referred to the county medical society, hospital association or EMS Advisory Committee for review.

RECOMMENDATION NO. 11

That the FMA request the Health Program Office, Department of HRS, to require that the state disaster plan components relative to county medical plans (health annex six) be submitted to the local county medical society, hospital association, and EMS advisory committee for review and comment prior to submission to the state for approval and that copies of any existing plans (health annex six) be immediately submitted to the aforementioned organizations for review.

Written Transfer Agreement—The Health Systems Agency of East-Central Florida, Inc., requested the FMA's position on transfer agreements. These transfer agreements are to serve for documentation of transfer of acute emergency patients to facilities capable of providing more extensive medical treatment.

RECOMMENDATION NO. 12

That the FMA adopt the following position statement on transfer agreements:

Any patient whose clinical needs exceed the capability of a facility or physician should be referred to a facility or physician who can provide optimal care for that patient.

However, the decision to transfer any patient must be made solely by the responsible physician. No patient should be transferred without prior agreement of the receiving physician and the consent of the receiving institution.

911 Emergency Phone System—Concern has been expressed over the slow progress in implementing the 911 emergency phone system on a statewide basis.

RECOMMENDATION NO. 13

That the FMA support the statewide implementation of the 911 Emergency Phone System in Florida.

Pediculosis and Scabies in Schools—It has come to the Board's attention that there has been a recent outbreak of Pediculosis and Scabies in schools around the state. It has also been noted that many children are being excluded from school even after effective treatment because of the presence of nits.

RECOMMENDATION NO. 14

That the FMA should notify the Department of Education and Health Program Office, Department

of HRS, that it supports the School Health Medical Advisory Committee's position with regard to treatment of Pediculosis and Scabies in that it is not necessary to exclude afflicted children from school after an effective application of pesticides, and that the presence of nits after treatment is also no cause for exclusion from school.

State Funding—School Health Services Act of 1974—The Florida School Health Services Act of 1974 has never been fully funded by the State Legislature. The intent of this piece of legislation was to insure that school children throughout the state would receive adequate health services.

RECOMMENDATION NO. 15

That the FMA support full state funding of the School Health Services Act of 1974.

Locum Tenens for Rural Physicians—

RECOMMENDATION NO. 16

That the FMA recognize as one acceptable approach to assisting rural medically underserved areas, the concept of utilizing primary care residents as Locum Tenens for rural physicians on leave for illness, obtaining CME requirements or vacation.

D.A.T.E. Association—Medical Advisory Committee—The FMA Committee on Drug Abuse has been requested by Florida Association of Drug Abuse Treatment and Education Programs that the Committee serve as their medical advisory committee. The D.A.T.E. Association is a newly formed non-profit organization representing the drug abuse treatment and education programs in Florida.

RECOMMENDATION NO. 17

That the FMA approve the request from the Florida Association of Drug Abuse Treatment and Education Programs that the FMA Committee on Drug Abuse serve as their Medical Advisory Committee.

Council on Scientific Activities (Amended—R.C. I)

The Board of Governors reviewed the functions of the Council on Scientific Activities during the past year and noted with pleasure the awards received by the *FMA Journal* for excellence. The Board also noted the continued development in the FMA Continuing Medical Education Program and commended the Committee on Continuing Medical Education for its hard work in the administration of this program.

The Board of Governors recommended to the Florida Medical Foundation approval of research grants from the FMF Research Program totaling \$9,539.00.

"Experimental and Clinical Use of Silicone Rods for Tendon Construction and Transfer in the Lower Extremities," Joseph C. Flynn, M.D., Orlando.

"An Interactive Computer Model of The Skin," Marc S. Karlan, M.D., Gainesville.

"Quantitative Assessment of Lung Tissue Damage," Martin Fisher, Ph.D., Gainesville.

1977 Annual Meeting—Scientific Program—The Board approved the scientific program presented by J. Lee

Dockery, M.D., Chairman of the Council on Scientific Activities which will allow physicians to obtain up to 20 hours CME mandatory credit at the FMA 1977 Annual Meeting.

Council on Specialty Medicine (Amended—R.C. I)

"Medicalegal Consultants"—There is an organization by the name of "Medicalegal Consultants, Inc." located in Gainesville. This group is advertising their willingness to testify on either side of a malpractice case. It is felt that it is unethical for physicians to advertise in this manner.

The Board referred the question of unethical conduct of medicalegal consultants to the Judicial Council with the request that the Judicial Council identify those involved and instruct the appropriate county medical society and specialty group to investigate their actions, and further request that PIMCO compile copies of depositions from such physicians so that they can be compared with past statements and made available to FMA members.

Nurse Practice Act—The Board has reviewed with concern the present draft of the proposed rules and regulations for the new Nurse Practice Act and finds them to be unacceptable. It was felt that the present draft would allow nurse practitioners to practice medicine.

The Board referred the recommendation of the Council on Specialty Medicine that the FMA seek through the appropriate regulatory agency modifications in the present draft of the proposed rules and regulations for the new Nurse Practice Act to the Committee on Allied Health Professions for implementation.

The Board requested the State Board of Medical Examiners to investigate and refer to the appropriate body for action, any nurse practitioner currently practicing in independent settings without physician supervision and to prosecute those nurses that are found to be practicing medicine.

Intravenous Injections—The Board approved the policy that a licensed physician may delegate procedures to his employee he deems commensurate with the employee's education, training and demonstrated ability, subject to the credentialing authority of a health care facility to which the physician is responsible. A technologist under the direction of a licensed physician may administer radiographic contrast agents and radiopharmaceuticals intravenously to patients.

Diabetes Screening Program—The Board approved the Diabetes Screening Program of the Florida Cooperative Extension Service.

Blue Shield—The Board expressed its appreciation to Blue Shield for its report on its efforts to improve claim processing and requested that this information be widely disseminated to physicians by specialty groups.

Patient Referrals—

RECOMMENDATION NO. 18

That FMA adopt the following Resolution:

WHEREAS, it has been routine procedure at state hospitals to send discharged patients to a Mental Health Center rather than to the physician who referred them, and

WHEREAS, the medical records on such patients have been sent to a Mental Health Center without regard for the patient's right to privacy, and have not been sent to the referring physician or clinic, and

WHEREAS, pressure has often been exerted on patients, through interviews and printed forms prior to their discharge, to go to a Mental Health

Center instead of their own physician who referred them, and

WHEREAS, continuity of care and protection of privileged information are essential to good medical care and require sending a patient back to his referring physician following specialized treatment;

THEREFORE BE IT RESOLVED, that the Florida Medical Association take all necessary action, including but not limited to, initiation of rule making proceedings to insure:

1. That patients upon completion of treatment in a state facility are referred back to the referring physician or clinic if mutually agreeable.
2. That patients are not discouraged from returning to the physician whom they had originally chosen.
3. That the referring physician or clinic is notified of anticipated discharge or trial visit.
4. That the appropriate reports are sent to the referring physician or clinic without delay.
5. That Medical Records are sent only to the referring physician or clinic unless otherwise specifically requested by the patient.

Specialty Group Recognition—The Board approved the application of the Florida Federation of Clinical Oncologists for recognition by the FMA.

Subcommittee on Administrative Medicine (Adopted—R.C. I)

The Board of Governors established a sub-committee chaired by Dr. Eugene G. Peek, Jr., M.D., Ocala, to provide liaison with the Florida Society of Administrative Medicine. The Committee was established to create a viable mechanism for providing guidance and assistance to the physicians working within the Department of HRS.

Committee on Allied Health Professions (Adopted—R.C. II)

Definition of an Allied Health Profession—The Board revised the FMA definition of an allied health care profession to include those groups whose members are involved in/or educated in a professional field and to substitute the term health care in place of medical care.

Criteria for Recognition of an Allied Health Profession—The Board approved expansion of the criteria for recognition of an allied health profession to require any group requesting recognition to have been in existence for a period of five years. Other criteria includes:

1. That a group requesting recognition be organized on a statewide level, or have the potential to do so.
2. That it be endorsed by the Florida Medical Association component group with which it most closely associates (when one exists).
3. That its purpose and needs are not covered or in conflict with an already existing organization.

4. That its structure will assist and not deter other related groups.
5. That a preliminary constitution and or bylaws state its organizational structure, purposes and aims.

FMA Recognition of Allied Health Professions—The Board granted FMA recognition of the following allied health professions: Florida Academy of Physician's Assistants; and Florida Society for Respiratory Therapy. This brings the total of recognized groups to 13.

Nurse Practice Act—The Board recommended major modifications to the proposed rules and regulations for the new Nurse Practice Act to assure physician supervision of the nurse practitioner, and requested the Board of Medical Examiners to investigate any nurse practitioner currently practicing in an independent setting and take appropriate action.

Committee on Sports Medicine (Adopted—R.C. II)

Designation as a Standing Committee—The Board of Governors designated the FMA's special Committee on Sports Injuries as a standing committee of the FMA under the Council on Medical Services and approved a change of Committee's name to the Committee on Sports Medicine.

School Trampoline Injuries—The Board voted to notify the Department of Education that the FMA has changed the policy adopted by the Florida School Health Medical Advisory Committee in 1974 regarding trampolines to provide:

"It is the opinion of the Florida Medical Association's Committee on Sports Medicine that trampolines are unsafe even under supervised conditions."

Curriculum for Physical Education Major—The Board recommended to the Board of Regents that courses in athletic training be part of the required curriculum for physical education majors.

Committee on Nursing Homes (R.C. V)

Review Teams—The Boards requested the Florida Hospital Association, Florida Nursing Home Association and the Florida Nurses Association to join the FMA in asking the Department of Health and Rehabilitative Services to include registered nurses on nursing home medical review teams, and exclude social workers from reviewing medical charts and records and making decisions regarding medical matters, and further that registered nurses be added to the medical review teams, just under the physician, and that these nurses be adequately compensated.

The Board adopted the position that physician members of the Department of HRS, nursing home medical review teams, who make medical decisions, be licensed to practice in the state and physicians accepting a position on a nursing home medical review team should personally participate in the review and not depend on the findings of other team members.

The Board requested the Department of HRS to develop a clear and succinct definition of the three levels of care in nursing homes and further, that the Department develop a nursing home review policy and procedures manual to be disseminated to each member of the medical review team, each nursing home administrator and each physician assigned a Medicaid provider number.

The Board approved the policy that the FMA continue to encourage its members to see their nursing home patients when medically necessary, and that the FMA also request nursing home medical directors to seek assistance from county medical societies in handling physicians who are not seeing their patients when it is medically necessary.

Blue Shield (R.C. V)

The Board received a report that Blue Shield is involved in problems in the areas of cost containment, the market place, Medicare, claims processing and physicians. The biggest problem this past year has been cost containment

and that if there is a rate increase, there will then be political problems. In the political area the legislature is trying to write insurance policies. There were problems with nurses wanting to be covered by Blue Shield. In the Medicare area, a new computer system put into effect January 1 is anticipated to give some relief in productivity in this area. Support from physicians for Blue Shield appears good.

RECOMMENDATION NO. 19

After careful consideration, the Board of Governors submits the following recommendations to the House of Delegates for amendment to the FMA By-laws.

AMENDMENTS TO THE BY-LAWS

Council on Medical Services

CHAPTER VIII—COUNCILS, Section 3—Duties, Functions, and Composition

Amend Item 4 to read:

"4. THE COUNCIL ON MEDICAL SERVICES shall direct and supervise the activities of the Association which normally are classified as medical services such as Public Health, Rural Health, School Health, Emergency Medical Services AND MEDICAL TELE-COMMUNICATIONS, Drug Abuse, AND SPORTS MEDICINE. It shall report its activities regularly to the Board of Governors through the Executive Committee."

(This amendment adds the area of emergency medical communications to the activities of the Committee on Emergency Medical Services, and creates a standing Committee on Sports Medicine under this Council.)

Board of Governors—Composition

CHAPTER VII—BOARD OF GOVERNORS, Section 1—Composition

Amend third paragraph to read:

"The Board at its discretion may select to serve on the Board of Governors in an advisory capacity, for a term of one year each, a representative from the Florida Department of Health and Rehabilitative Services, from the State Board of Medical Examiners, from the Board of Directors of Blue Shield of Florida, Inc., AND FROM THE BOARD OF DIRECTORS OF THE FLORIDA PHYSICIANS INSURANCE RECIPROCAL, . . ."

(remainder of paragraph unchanged).

(This allows a representative of the Board of Directors of the Florida Physicians Insurance Reciprocal to serve on the Board in an advisory capacity at the discretion of the Board.)

Alternate Delegates—Tenure and Interim Status

CHAPTER IV—HOUSE OF DELEGATES, Section 12—Alternate Delegates

Amend to read:

"SECTION 12. TENURE OF ALTERNATE DELEGATES
"Each component society shall select alternate delegates corresponding in number to the delegates to which it is entitled, and shall designate to the Secretary of the Association the order in which they are to serve."

"EACH ALTERNATE NOT SEATED AS A DELEGATE AT THE ANNUAL MEETING SHALL CONTINUE TO SERVE AS AN ALTERNATE UNTIL THE NEXT ANNUAL MEETING AND FOR ALL INTERIM OR CALLED MEETINGS BETWEEN ANNUAL MEETINGS, UNLESS THE COMPONENT SOCIETY BY CERTIFICATION OF ITS PRESIDENT OR SECRETARY DULY DESIGNATES A DIFFERENT ALTERNATE. In order to be seated, an alternate must show certification by the president or secretary of his component society."

(This amendment establishes a tenure and interim status for alternate delegates selected by component societies.)

Alternate Delegates—House of Delegates Handbook

CHAPTER IV—HOUSE OF DELEGATES, Section 18—Handbook for Members of House of Delegates

Amend last sentence to read:

"SECTION 18. HOUSE OF DELEGATES HANDBOOK
". . . It shall be mailed to each delegate AND ALTERNATE at least thirty days prior to the Annual Meeting."

(This provides for mailing of the Handbook for the Annual Meeting of the House of Delegates to the alternates as well as to the delegates.)

President's Address

The Reference Committee expressed its appreciation for the carefully prepared message of the President as delivered at the opening session of the House of Delegates. The Reference Committee noted that his address was timely, informative, and inspiring to all those delegates and guests present.

The motion of the Reference Committee that this very fine address by President MaCris be filed carried.

Remarks of Speaker

The Reference Committee reviewed the address of the Speaker and expressed its appreciation to him for his organization and conduct of the House during his tenure as Speaker. The Reference Committee noted that his address at the opening session of the House of Delegates was commensurate with his performance as Speaker.



These notables were among the guests at the Deans' Luncheon, held in conjunction with the Annual Meeting. Left to right: FMA President Jack A. MaCris, M.D., St. Petersburg; Dean E. M. Papper, M.D., of the University of Miami School of Medicine; Acting Dean William B. Deal, M.D., of the University of Florida College of Medicine; Acting Dean Hollis Boren, M.D., of the University of South Florida College of Medicine; and FMA President-Elect Louis C. Murray, M.D., Orlando.

The motion of the Reference Committee that the remarks of the Speaker as presented be filed carried.

Report of Public Relations Officer

The motion of the Reference Committee that the report of the Public Relations Officer be adopted carried.

Public Relations

Vernon B. Astler, M.D., Public Relations Officer

Since the founding of the public relations department in 1976 as a three-person office, a number of noteworthy advances have been made to make the public aware of the Florida Medical Association and its actions, both within and outside the community.

The primary goal of the department following approval of the initial budget was to experiment with various communication and awareness techniques and tools to determine and test cost, penetration, effectiveness, reception and ability to maintain interest by department personnel. In review, tests conducted by the department have found initial receptivity on the part of the media sources involved to be positive, as well as a good reception by those physicians participating.

1. **Print Media**—The print program has consisted in part of a regularly established weekly release dealing with a topic of general medical interest. This has been particularly well received by level two dailies and weeklies across the state.

a. A bi-monthly health column has been inaugurated and reached its initial goals and is currently being sponsored by 21 county medical societies. It is being carried with regularity by 77 newspapers throughout the state, and a recent poll of all newspapers in the state indicated that the column is well received by all newspapers, whether they utilize the material or not.

In addition, a recent survey of 97 hospital newsletter editors indicated that all but three publications would like to include the column on a regular basis.

b. There has been an effort to produce and place special feature stories on various aspects of medicine.

c. The regular flow of news comments on medical/para medical issues has been increased. A number of newspapers in the state have now recognized the FMA as a source when seeking verification and comment on such issues.

2. **Electronic Media**—A 15-minute bicentennial program was prepared and distributed in early August and received excellent reception by radio stations across the state.

A series of five, 5-minute radio programs entitled "Pulse" have been produced. Three have been distributed with an initial reaction indicating a very good market penetration. The subjects include a general review of the state of medicine; a dialogue between Doctors Astler and Annis; CPR; "Back to School" Hints; and strokes. A primary host for this series was used with an occasional local host for a specific subject.

3. **Television**—Because of the cost and difficulty of penetrating the television market, a pilot effort to develop 30-second public service announcements was adopted. This was approached cautiously to determine whether or not a message, basically stressing our promedicine themes, wrapped in a public responsibility code, would get aired on free time.

One PSA has been released and is still being aired by the majority of television stations across the state. Numerous requests for additional PSA's have been received by the Association.

A "news feature" on sports medicine was produced also and was aired during "prime time" on the sports segment of news shows by almost every television station.

Again, this was an experimental project to determine the reception to this type of feature.

4. **Film**—A half hour documentary film was produced by the Public Relations Department this year, and was aired on stations across the state in January. The film, "A Matter of Life . . ." dealt with medical care available in Florida, and underscored the role of the physician in making modern medical achievements meaningful in the lives of Floridians.

This film was a report to the people of Florida to acquaint them with the advances of medical science and the quality of care available to the citizens of this state. The material was presented dramatically, effectively and honestly. All medical situations were filmed live and represent actual operations or treatment of patients by Florida physicians.

This project was a major undertaking by the Association and represents untold hours of time and effort by the entire FMA staff.

It has been made available to schools, service clubs, civic organizations, state medical societies and other groups as part of our public service program. It will be shown on public service television across the state in the next few months. County medical societies are encouraged to borrow the film from the Association for use in their communities. Several county medical societies have purchased prints of the film for their society.

The result of the post interview survey on the film indicates that the viewer interest was extremely high, and the audience percentage quite good.

5. **Communications**—There has been a concentrated effort to improve communications with the FMA membership. The Public Relations Department has assumed the development and production of many line services of the FMA. These include the Gray Paper; Briefs; President's Memo; and production of the Legislative Bulletin. The Professional Liability Legislation Program newsletters, "Survival '76" and "Priority '77" also were produced by the Public Relations Department. A redesign of communication logos has been completed by the Department in an attempt to make communications to members easily identifiable and up-to-date in appearance.

Inserts for the FMA Journal highlighting important subjects of concern to the membership have been prepared by the Public Relations Department. These include Summaries of FMA Board of Governors Meetings; important information concerning the FMA Professional Liability Legislative Program; and meeting activities of the Association.

6. **Public Relations Seminar**—A Public Relations Seminar was held September 25-26, 1976, at the Host International Hotel, Tampa, Florida. It should be stressed that this was a working seminar with over 60 participants. The purpose of this workshop was to stimulate county medical societies' public relations programs, working with the expanded FMA Public Relations Program. A public relations handbook and a public relations packet with general PR information was prepared for county medical societies' use.

7. **Speakers Bureau**—An initial beginning on the development of a statewide speakers bureau under the Public Relations Department has been undertaken. Physicians with outstanding speaking ability are available for speaking engagements for civic organizations, regional meetings or conventions.

Report of AMA Delegates

The motion of the Reference Committee that the report of the AMA Delegates be adopted carried.

Report of AMA Delegates

James T. Cook., M.D., Chairman

The entire FMA Delegation expressed their appreciation to Dr. Francis T. Holland, Tallahassee, for his many years of service as Chairman of Florida's delegation to the AMA. Dr. Holland's term as an AMA Delegate expired December

31, 1976 and he did not seek re-election. He served as a Delegate for 22 years.

The AMA Delegation and the FMA wholeheartedly supported Dr. Holland as a candidate for Vice-President of the AMA, a post to which he was elected at the AMA Annual Meeting in June, 1976.

It has been my pleasure to serve as Chairman of the AMA Delegation during the past year and I greatly appreciate the assistance of the Vice-Chairman, Burns A. Dobbins, M.D., Fort Lauderdale, and the entire delegation who have worked diligently in support of the best interests of Florida's physicians in the AMA's House of Delegates.

Florida is represented on the AMA Board of Trustees by Dr. Jere W. Annis, Vice-Chairman of the Board and Dr. Francis T. Holland as Vice-President of AMA. Dr. Burns Dobbins serves on the Judicial Council and Dr. Richard Connor on the Council on Education. Dr. Rufus Broadway serves on the AMA Committee on Long Range Planning and Development and Dr. Joseph C. Von Thron is a member of the AMPAC Board.

All major actions of the House of Delegates have been reported in the AM News and the following is a summary of the FMA delegate's activities regarding matters considered by the AMA House of Delegates which are of major concern to the FMA:

National Health Insurance—The crucial issue considered by the AMA House of Delegates at its Clinical Meeting in December, 1976, was the question of adoption of a comprehensive national health insurance program. Your delegates, following instructions of the FMA House of Delegates, tried diligently to gain support of a position in favor of catastrophic health insurance funded by the private insurance sector of the insurance industry. Dr. Joe Von Thron made an eloquent presentation before the AMA House in opposition to a comprehensive national health insurance program.

Your delegation voted unanimously against the AMA's National Health Insurance Bill (HR 6222).

Resolution Re Social Security Numbers—Your Delegates supported adoption of the resolution submitted by the California Medical Society regarding social security numbers. This resolution resolved that the AMA express total opposition to the use of the social security number as a universal identifier and encourage all medical societies, all hospitals and other providers of medical care to oppose the use of the social security number as a universal number identifier. The House passed an amended resolution that any universal identifying number should not be placed on patient charts.

Resolution 76-10, JCAH and Audit Posture — This resolution adopted by the FMA House of Delegates in May, 1976, resolved that the FMA go on record as favoring some solution to the problem regarding the inconsistent stance between the JCAH and the AMA with regard to the 24 hour admission review rules.

Resolution 76-13, PSRO 24 Hour Review — This resolution adopted by the FMA House of Delegates in 1976 resolved that:

The FMA considers 24-hour review in any form, expensive and nonconductive to good patient care and advises the physicians of Florida to resist by all legal means 24-hour review procedures including those imposed by PSRO and enlists AMA resistance to the PSRO formulated 24-hour reviews.

These two resolutions were considered jointly and the AMA House of Delegates adopted the following amended substitute resolution:

That the American Medical Association continue to resist by whatever means necessary the imposition of mandatory review within 24 hours of admission by governmental agencies and others.

Report of Committee on County Medical Society Presidents

The motion of the Reference Committee that Recommendation No. 1, be adopted carried.

The motion of the Reference Committee that Recommendation No. 2 be received as information carried.

The Reference Committee noted that Recommendation No. 3, was an observation and not truly a recommendation and, therefore, no action was taken by the Reference Committee.

The Reference Committee moved a substitute for Recommendation No. 4. The motion carried.

The motion of the Reference Committee that the Report of the Committee on County Medical Society Presidents be adopted as changed carried.

Committee on County Medical Society Presidents

John M. Hamilton, M.D., Chairman

This Committee has held no formal meetings during this Association year, however, a survey was conducted of the county medical societies as to problems that may be occurring locally, but of which FMA might not be aware. Based upon the findings of this survey, the following recommendations are submitted.

Recommendation No. 1

That the Board of Medical Examiners should act more promptly in suspending the licenses of those found to be incompetent or fraudulent.

Recommendation No. 2

(Received as information)

That a stand be made on the mushrooming health testing centers, probably through legislative action.

Recommendation No. 3

(Observation)

That otolaryngologists have ignored the Judicial Council's ruling by listing themselves in yellow pages as plastic surgeons.

Recommendation No. 4

That grievance committees, Judicial Councils, etc. are becoming quasi-public bodies in peer review procedures and must follow legal processes. We need to have a definite manual of procedure if we are going to continue these efforts and we need to greatly expand the State Board of Medical Examiners' investigative staff to investigate and make recommendations. We favor a manual that precisely outlines procedures on a local level, as we feel that no one can know the situation as well as those on the local scene.

Report of Special Committee on Long Range Malpractice Planning

The motion of the Reference Committee that the report of the Special Committee on Long Range Malpractice Planning be adopted carried.

Special Committee on Long Range Malpractice Planning

William J. Dean, M.D., Chairman

This Committee has had no formal meetings. Consultation with the President, reflecting the feeling of the Board of Governors, has determined that no new approaches are needed at the moment. Activities during the 1976 Florida Legislature have been allowed to settle, and no new activities currently appear indicated.

Ongoing activities include monitoring and review of malpractice actions of other states and the AMA Long Range Committee, as well as liaison with the FMA Board of Governors and Legislative Committee as to their present legislative programs.

Long range plans are to reassess Florida's 1975 and 1976 legislative programs, with appropriate recommendations to the Board of Governors.

Report of Florida Medical Foundation

The motion of the Reference Committee that an additional sentence concerning a Committee on Medical Education be added at the end of the report of The Florida Medical Foundation carried.

The motion of the Reference Committee that the amount of \$30,811.65 be added at the end of the line after the word "Totals" in Paragraph Five of this report carried.

The motion of the Reference Committee that the report of the Florida Medical Foundation be adopted as changed carried.

Florida Medical Foundation

Eugene Peek, Jr., M.D., President

The Florida Medical Foundation has continued a very active role during the past year. The following is a summary of its activities. Other ongoing and anticipated activities and programs are outlined in the report of the Board of Governors and in reports of Councils and Committees included in the Delegates' Handbook.

Peer Medical Utilization Review — The Foundation renewed its contract with Blue Shield to be effective July 1, 1976, to continue to conduct Peer Medical Utilization Review. Under the contract, the Foundation coordinates all local medical peer review activities with the state medical peer review committee and the appeals process in all counties except Dade and Monroe counties. The Florida Medical Foundation has signed a contract with Group Health Inc. (GHI), the fiscal intermediary for Dade and Monroe to do peer review in the same manner as for the rest of the state.

The activities of the PMUR Committee are summarized in the report of the Council on Medical Systems included in the Delegates Handbook.

Medical Student Loans — The Foundation in its annual report to the House of Delegates in 1976, informed the House regarding the alarming number of students granted loans through the Foundation's Student Loan Program, who had defaulted on their loans. The Foundation as guarantor of these loans was responsible for repayment in full to the bank. This seriously jeopardized the program and brought about an indefinite moratorium in granting of loans until such time as financial stability is restored.

An effort has been made to obtain funds for the Foundation through the sale of a limited printing of the painting "Caduceus" by Lee Adams. The paintings are available in return for a \$300.00 tax deductible donation to the Foundation. The proceeds received from the sale of the prints, which to date totals \$30,811.65, will be utilized by the Foundation for its primary purposes:

1. Improvement of the health and of the medical care of people of Florida.
2. Sponsorship of graduate and postgraduate medical education.
3. Aid to persons needing financial assistance who are pursuing an education in medicine.
4. Aid to deserving indigent or destitute physicians in need of assistance.
5. Promotion and sponsorship of medical research.

Research Grants — The Foundation approved grants for the following research projects totaling \$7,990.54: "Experimental and Clinical Use of Silicone Rods for Tendon Reconstruction and Transfer in the Lower Extremities" by Joseph C. Flynn, M.D., of Orlando.

"An Interactive Computer Model of the Skin", by Marc S. Karlan, M.D., of Gainesville.

"Quantitative Assessment of Lung Tissue Damage", by Martin J. Fisher, Ph.D. of Gainesville.

The Foundation receives numerous applications for worthy projects, however, awarding of grants is restricted due to limited funds.

Woman's Auxiliary — The Foundation is grateful to the Florida Medical Association's Auxiliary for their continued efforts to raise funds for the FMF through various Auxiliary projects.

Perinatal Intensive Care Program — The Foundation has continued to serve as fiscal administrator for the Neonatology Intensive Care Program. The program, which was previously funded by the FRMP, is being continued through a \$20,000 grant from the National Foundation.

The primary goal of the project is to support programs designed to attain optimal use of measures for the prevention of birth defects and to demonstrate and teach the use of exemplary methods for the diagnosis, evaluation, or treatment of patients with birth defects. Richard J. Boothby, M.D., serves as Program Director of this project.

Drug Abuse — The Foundation served as fiscal administrator for a contract with the Department of Health and Rehabilitative Services to conduct a study of Florida's 29 residential drug abuse treatment centers. This study which was conducted by the FMA's Committee on Drug Abuse has been widely acclaimed for its completeness and objective contributions for improvements in the availability and utilization of medical services in Florida's drug abuse treatment centers.

A Committee on Medical Education has been made a part of the Florida Medical Foundation.

Report of Judicial Council

The motion of the Reference Committee that on line 20 of the second page of the Report of the Judicial Council, that the word "Medical" in parenthesis be deleted and the word, "Malignant" be inserted carried.

The motion of the Reference Committee that this substitution be adopted carried.

The motion of the Reference Committee that the Judicial Council Opinions be adopted as printed in the handbook carried.

The motion of the Reference Committee that the Judicial Council continue to study the problem of yellow page listings in an attempt to make it as equitable as possible to the needs of all practicing physicians carried.

The motion of the Reference Committee that the Report of the Judicial Council be adopted as changed carried.

Judicial Council

William W. Thompson, M.D., Chairman

The 1977 Annual Report of your Judicial Council will summarize the major areas of activity that encompassed the Council's time since the last Annual Meeting of the Florida Medical Association held in May 1976. The Council has continued to fulfill its duties as prescribed by the Bylaws of the Florida Medical Association in an efficient and economical manner. During the interim, your chairman has reported to the Board of Governors up-to-date summations of major areas of Council concern. The Council has formally met and conducted its business on the following dates: May 9 and July 10, 1976, in Hollywood; September 18, 1976 and January 27, 1977, in Orlando. The membership of the Council has been as follows: William W. Thompson, M.D., Chairman; John J. Cheleden, M.D., Vice Chairman; James A. Winslow, Jr., M.D.; Vincent P. Corso, M.D.; and Joseph H. Davis, M.D. During the year, the staff person assigned to the Judicial Council from the Florida Medical Association was changed. Mr. Ed Hagan has been assigned to other duties dealing with scientific activities of the Association, and Mr. John Thrasher has assumed those duties relating to the Council formerly handled by Mr. Hagan. The Council wishes to express its extreme gratitude and appreciation for Mr. Hagan's outstanding services rendered to the Council during the several years he provided staff assistance.

The Council's activities are summarized under the appropriate headings as follows:

1. **Telephone Directory Yellow Page Listings** — Since the January 1976 meeting of the House of Delegates, wherein the House amended its 1974 policy governing the listings of members in telephone directories, your Council has handled numerous inquiries relative to the interpretation of this amendment. The specific amendment allows members of the Florida Medical Association to list, in addition to regular alphabetical yellow page listings, only under those specialties that have certifying boards and which boards are approved by the American Medical Association. It was felt by your Council that the public's interest could best be served and the ethical considerations met if certain clarifying modifications of the specialty-subspecialty headings were made. These modifications in no way change the substantive requirements of the policy on yellow page listings, but only provided clarification to those listings that the average lay person would have difficulty defining. The following list sets out those approved modifications:

From:	To:
Anatomic Pathology	Pathology—Anatomical
Cardiovascular Disease	Cardiovascular Diseases (Heart)
Child Neurology	Neurology—Child
Child Psychiatry	Psychiatry—Child
Colon and Rectal Surgery	Surgery—Colon and Rectal
Dermatology	Dermatology (Skin)
Dermatopathology	Dermatopathology (Skin Pathology)
Endocrinology and Metabolism	Endocrinology & Metabolism (Glandular & Metabolism Disorders)
Gastroenterology	Gastroenterology (Digestive System)
Gynecologic Oncology	Gynecologic Oncology (Malignant Diseases of the Female Organs)
Hematology	Hematology (Blood)
Medical Oncology	Medical Oncology (Malignant Diseases)
Nephrology	Nephrology (Kidneys)
Neurological Surgery	Surgery—Neurological
Obstetrics and Gynecology	Gynecology and Obstetrics
Ophthalmology	Ophthalmology (Eyes)
Orthopedic Surgery	Surgery—Orthopedic
Otolaryngology	Otolaryngology (Ear, Nose and Throat)

Pediatric Surgery
Plastic Surgery
Surgery
Thoracic Surgery

Surgery—Pediatric
Surgery—Plastic
Surgery—General
Surgery—Thoracic

Representatives of your Council and staff have met, corresponded and communicated with representatives of the major telephone companies throughout the state regarding implementation of the House of Delegates policy on yellow page listings. These meetings have been most productive, and a continuing liaison exists between your Council and the major telephone companies in Florida.

An often repeated inquiry to the Council deserves some particular mention in this report. We have been asked on numerous occasions to respond to the meaning in the policy statement of the precise definition of the words "practice limited to." Section III, Subsection 4, of the policy guidelines provides as follows: "In addition to the regular alphabetical listing, a physician may list himself under no more than two specialty or subspecialty headings, provided he is board certified, or qualified in, or limits his practice to, the primary specialty . . .". Your Council has interpreted this language to mean the following: That the intent of the phrase "practice limited to" is to require that anyone who so lists under a particular specialty or subspecialty using the criteria "practice limited to" must, in fact, limit his practice to that specialty or subspecialty. As an example, an otolaryngologist who lists as an otolaryngologist could not logically or ethically, under this interpretation, list under any other specialty or subspecialty using as his authority "practice limited to". The only way, for instance, an otolaryngologist who lists as such could additionally list himself under the heading of "Plastic Surgery" would be for him to be either board certified or board qualified in plastic surgery.

Specific opinions relating to yellow page listings rendered since the last report are set out in a separate section of this report.

2. Health Testing Centers — The Council considered during the year the issue of the numerous health testing centers that have been organized throughout the State. The centers have been established to provide low cost medical testing services for the citizens of Florida. It has been the concern of the Council that these programs will lead to poor quality medicine with increased cost to the patient if proper control and regulation is not provided. Accordingly, the Council adopted unanimously a position that it advise the Board of Medical Examiners of the facts it had developed concerning health testing centers, and advised the Board that it was the opinion of the Council that such operations may constitute the practice of medicine, in violation of the Medical Practice Act. In addition to this action, a letter to the Attorney General of Florida was written to request that he investigate these centers to determine if they may be violating certain laws regulating advertising under the Florida "Little Fair Trade Practices" Act. The Council was informed by the Attorney General that three such lawsuits had, in fact, been instituted, and that certain legislative activity was under consideration. The Council has been informed that Representative David Lehman, M.D., has introduced legislation for consideration by the 1977 Florida Legislature that would adequately control and regulate these health testing centers in the public's interest.

3. Judicial Council Guidelines for Improvement and Monitoring of Educationally Deficient Physicians — During the last year, your Council developed guidelines to provide an orderly procedure for handling the cases of certain physicians whose practice indicates lack of attention to a good continuing education program. It is not the intent of this Council to intervene in all instances in which there is some evidence of educational neglect. However, this Council must initiate some remedial action to correct the habits of those few physicians whose partial or total disregard to continuing medical education renders them incompetent to practice medicine or otherwise poses some threat to the welfare of their patients. This procedure will apply to those cases referred to this Council by the Executive Committee or the Board of Governors.

4. Grievances — During the past year, the Council continued to handle routine grievances that were referred to it from individuals throughout the state. The Council maintained its procedure of allowing the county medical societies to resolve these local grievances and report their findings to the Council. The Council, of course, retains the right to withdraw these grievances from the local society if they are not acted upon in a reasonable time. Additionally, an individual may appeal a decision of a local county medical society grievance committee to the Council. The Council has noted that some thirty-two grievances have been processed, and final decisions rendered during the last year. This system seems to work effectively in resolving these issues, and the Council encourages each county medical society to handle grievances in an efficient and expeditious manner.

5. Osteopathy — FMA By-Laws Amendment — At the 1976 FMA Annual Meeting, the House of Delegates adopted a number of amendments to the By-laws, which opened membership of the Florida Medical Association and its component medical societies to osteopaths who have completed an AMA approved internship and/or residency program. The Board of Governors has requested that this Council instruct the component county medical societies to amend their by-laws accordingly so that they are not in conflict with these changes that have been made to the FMA By-laws regarding qualifications for membership.

6. Liaison with the Board of Medical Examiners — The Council has continued a close liaison with the Board of Medical Examiners, and conducted a joint meeting on July 10, 1976, with the Board. In addition to this meeting, Dr. George Palmer, Executive Director of the Board of Medical Examiners, your Council, and the Florida Medical Association's PMUR Committee met in the Tampa area to discuss the obligations and duties of the members of these Committees who were deputized by the Board of Medical Examiners to conduct investigations for the Board.

7. Handbook on Law and Ethics — During the past year, the Council has initiated work on a handbook dealing with law and ethics. It is the intent of this publication to provide members of the Florida Medical Association with opinions of the Florida Medical Association's Judicial Council and pertinent sections of Florida Law dealing with the practice of medicine. Additionally, appropriate sections of the American Medical Association's Judicial Council Opinions and Reports would be included. This is a long-range project that will require a great deal of staff attention in order to properly review appropriate material for inclusion in the Handbook. It is hoped that within the next year, a draft of the Handbook will be finalized for consideration.

8. Physicians Who Advertise Their Willingness to Testify in Medical Malpractice Cases — Your Council has reviewed during the past year your request that the Council attempt to identify those physicians involved in advertising their willingness to testify in a medical malpractice case. It is the opinion of the Council that these physicians should be identified by the local medical societies and these societies should investigate their actions to determine if such advertising is unethical. Accordingly, your Council has advised each county medical society of its concern regarding this issue and requested that they take appropriate action.

9. Opinions of the Judicial Council—During the last year, the Council has rendered the following opinions:

Opinion 76-1 — Exculpatory contracts between physicians and patients are considered unethical if they are in any way coercive of the patient.

Opinion 76-2 — In the opinion of the Judicial Council a physician may respond to an invitation from a public agency to submit a bid to provide professional services. Such a proposal may include a schedule of the physician's fees, biographical information and professional and academic qualifications, including specialty certifications, memberships and fellowships. The proposal may contain a brief description of the physician's specialty interests. Self-aggrandizing statements must be avoided. Any contractual relationship consummated between the agency and the physician must be within the bounds of the ethical criteria

for contracts as interpreted by the Florida Medical Association.

Opinion — 76-3 — In the opinion of the Judicial Council, abortion clinics and other health care facilities with which physicians are associated may mail or distribute in some other manner to physicians in their areas on a one-time basis only, pamphlets or other publications describing services available. Such information should not be sent directly to patients. It is an established ethical principle that solicitation of patients is unethical. It is the judgment of the council that any abortion clinic or other health care facility in which physicians are involved is guilty of solicitation if it systematically and periodically directs informational or promotional literature to physicians. It is equally guilty of solicitation if such information is distributed indiscriminately to prospective patients or users of the facility's services, unless such information is sent in response to specific individual request. The fact that no physician's name might appear in the printed matter is totally immaterial. A physician may not do indirectly that which he may not do directly.

Opinion 76-4 — In the opinion of the Judicial Council sexual relations within the physician-patient relationship are unethical. Such relationships are not the practice of medicine and violate the Oath of Hippocrates, which prohibits "the seduction of females or males, bond or free".

Opinion 76-5 — In the opinion of the Judicial Council a physician may charge for both a consultation and an operative procedure on the same patient in the same day, provided no law or pre-existing contract is violated. The fee for both the consultation and the operative procedure should be commensurate with services rendered.

Opinion 76-6 — In the opinion of the Judicial Council a CMS may determine whether or not a particular modifier (e.g., explanatory language relating to hours of practice, limitations of practice, etc.) for an approved specialty or sub-specialty may be authorized, subject to restrictions contained in the policy of the FMA, Inc., governing the listing of members in the telephone directories (white and yellow pages), adopted by FMA House of Delegates, May 1974, and amended in January 1976 [See Journal of the Florida Medical Association (Proceedings Issue) July 1974, pp. 539-540; and Journal, Florida Medical Association, March 1976, p. 222].

Opinion 76-7 — In the opinion of the Judicial Council, descriptive headings for physician telephone directory specialty headings would be ethical, provided they are listed beside or below the specialty or subspecialty heading.

RESOLUTION NO. 77-4

Risk Management

Palm Beach County Medical Society

The motion of the Reference Committee that Resolution 77-4 be adopted carried.

Resolution 77-4

Risk Management

RESOLVED, That the FMA immediately and diligently attempt to encourage legislative repeal or change in the law, and be it further

RESOLVED, That if legislative relief is not forthcoming that the FMA seek relief by a challenge to the constitutionality of the law in the Supreme Court of the State of Florida, and be it further

RESOLVED, That while the law's constitutionality is being challenged, that the FMA seek a temporary injunction prohibiting the implementation of the law.

RESOLUTION NO. 77-6

1977 Mandatory Assessment

Sarasota County Medical Society

The Reference Committee reported on testimony heard as to the need of the Florida Medical Association for additional funds to continue at the present high level of expertise in public relations and the legislative program.

The excellent results of the public relations campaign through the showing of the film, "A Matter of Life . . .", radio spots, etc., proves the need for further expenditure of funds in these efforts. The Committee had learned that production of a second film is to begin in the very near future. Legislative and legal efforts to salvage our 1976 PLI Program will be expensive. New threats to our profession through governmental intervention with HSA's, PSRO's, and National Health Insurance will require greater effort and expenditures. It will be necessary for the Association to have a continuing fund specifically earmarked to meet the challenge that lies ahead. Having received testimony from many members who volunteered their views at the Reference Committee meeting, the Reference Committee offered a substitute for Resolution No. 77-6 consisting of a By-Laws amendment and moved its adoption. It was noted that, in compliance with the By-Laws, the Board of Governors has considered and unanimously concurs in this recommendation. An amendment was offered to delete the parenthetical phrase earmarking part of the dues for public relations and legislative activities. The amendment filed to carry. The motion of the reference committee to adopt the substitute resolution was adopted. Upon a motion to reconsider there was discussion of the reasons for the motion and the necessity to reconsider. The motion to reconsider carried. Several suggested amendments were made but did not carry. A motion to insert the word "Educational" after the word "Legislative" in the parenthetical phrase carried. A motion to adopt the By-Laws amendment as amended as substitute for Resolution No. 77-6 carried.

Substitute Resolution No. 77-6

By-Laws Amendment

Chapter X — Income and Expenditures, Section 2 — Dues: AMEND this paragraph to read: "1. Annual Dues — Annual dues shall be assessed, as hereinafter provided, by the House of Delegates and shall currently be \$175.00 per year (\$50.00 of

which is to be earmarked for public relations and legislative educational activities) for active members . . . (Remainder of section to remain unchanged.)

Resolution No. 77-10
Interim Meetings — House of Delegates
Lee County Medical Society

The motion of the Reference Committee that Resolution No. 77-10 be adopted carried.

Resolution 77-10
Interim Meetings—House of Delegates

RESOLVED, That interim or called meetings of the House of Delegates of the Florida Medical Association be limited to two days and be held on a weekend, unless pressing business dictates more time be used.

Resolution No. 77-14
Physicians Expert Testimony
Duval County Medical Society

The motion of the Reference Committee that Resolution 77-14 be adopted carried.

Resolution 77-14
Physicians Expert Testimony

RESOLVED, That the Code of Ethics of the Florida Medical Association, Inc. be amended to provide that it is unethical for a physician in Florida to testify as an expert on a subject unless he is actively engaged in the practice of the medical subject under discussion, and be it further
RESOLVED, That violations of this ethic will subject such physician to appropriate disciplinary action by his component county society, and be it further

RESOLVED, That in the event a non-resident physician violates this ethic, that a formal complaint be filed with the medical association of the state of his residence.

Resolution No. 77-15
Memorial Resolution: J. G. Converse, M.D.
Polk County Medical Society

The Reference Committee agreed with the intent of this Resolution, however, it felt that it was not appropriate to bring it before a Reference Committee, and therefore moved that Resolution No. 77-15 be received as information. The motion carried.

Resolution No. 77-17
Disabled Physicians
Volusia County Medical Society

The motion of the Reference Committee to amend the first paragraph of the RESOLVED of Resolution 77-17 carried.

The motion of the Reference Committee that Resolution No. 77-17 be adopted as amended carried.

Resolution 77-17
Disabled Physicians

RESOLVED, That the Florida Medical Association Board of Governors study the programs as developed by the states of Georgia and Washington to aid in the early diagnosis, treatment, and rehabilitation of physicians, and study the feasibility of adopting such a program as a first priority of business with the following objectives in mind:

1. Early detection of the disabled physician with the least possible damage to his professional reputation.
2. Adoption of a method of recovery for the disabled physician best suited to his needs, his patients' care, his community image, his family's well being, and his professional standards, and as such the maintenance of anonymity as much as possible.
3. Development of a plan of restoring, upon recovery, the physician to his role as a useful, respectable practicing physician, keeping his best interests and wishes in mind.

Resolution No. 77-18
Relationship Between Florida Medical Association
and Component Medical Societies
Monroe County Medical Society

The Reference Committee felt that it did not have all the facts at its disposal and felt that this was a multifaceted problem; therefore the Reference Committee moved that Resolution No. 77-18 be referred to the Board of Governors for their investigation and recommendations. The motion carried.

Resolution 77-18
Relationship Between Florida Medical Association
and Component Medical Societies
Monroe County Medical Society

[NOT ADOPTED — REFERRED TO BOARD OF GOVERNORS]

WHEREAS, The Monroe County Medical Society is a duly chartered component of the Florida Medical Association, and

WHEREAS, The membership of the Monroe County Medical Society fully subscribes to the letter and intent of the Charter and Bylaws of the Florida Medical Association, and

WHEREAS, A precise relationship exists between component Societies, the Association and its Councils regarding matters of complaint, investigation, peer review and discipline (Chapter XI, Section 4; Chapter I, Section 4; Bylaws, Florida Medical Association), and

WHEREAS, The Judicial Council and its Chairman have taken purposeful action outside the framework of this precise relationship without consultation with or advice of the duly elected officers and representatives of the Monroe County Medical Society, thus resulting in loss of public confidence in the medical community, and promotion of an atmosphere of disharmony, tension, and general upheaval; be it therefore

RESOLVED, That the House of Delegates of the Florida Medical Association reaffirm the principles as set forth in the Charter and Bylaws of the Association that matters of complaint, investigation, peer review and discipline be the initial responsibility of the component societies and be it further

RESOLVED, That the Association and/or its Councils and Committees not take action in matters of complaint and investigation regarding its members without initial consultation with or the advice of his or her society's officers or representatives.

Resolution No. 77-21

FMA President

Ralph M. Stephan, M.D.

The Reference Committee had reviewed the officers stipends and considered them reasonable and saw no reason for a change at this time. The motion of the Reference Committee that Resolution No. 77-21 not be adopted carried.

Resolution No. 77-22

FMA Delegates to AMA

Brevard County Medical Society

The Reference Committee reported that it would be impractical to accomplish and difficult to define what would be an important and controversial issue as contained in this resolution.

The motion of the Reference Committee that Resolution No. 77-22 not be adopted carried.

Resolution No. 77-23

Board of Medical Examiners

H. Quillian Jones, Jr., M.D.

The Reference Committee had heard testimony in favor of Resolution No. 77-23, and felt that the original intent of this legislation, namely, the influx of Latin physicians in large numbers into the United States during the crisis years, has now subsided. The Committee also noted that the programs for the re-education of Latin physicians are being phased out and that there is no longer a need for this type of examination.

The motion of the Reference Committee that Resolution No. 77-23 be adopted carried.

Resolution 77-3

Board of Medical Examiners

RESOLVED, That the Florida Medical Association recommend to the Florida Legislature the repeal of F. S. 455.015 which requires licensing boards, including the State Board of Medical Examiners to provide licensing examinations in a foreign language.

Resolution No. 77-24

Investigation (Report 76-IM-4)

Eugene R. Valentine, M.D. (Delegate)

The motion of the Reference Committee that Resolution No. 77-24 be adopted carried.

Resolution 77-24

Investigation (Report 76-IM-4)

RESOLVED, That the Board of Governors render a report to the membership of their findings on Resolution introduced by Okaloosa County Medical Society at the Interim House of Delegates Meeting 1976 (Professional Liability Packet, Item — 14 in Supplement Report Number 76 IM-4) which requested investigation of the advisability of seeking legislation which would give "privileged communication" status to all medical records.

Resolution No. 77-26

Telephone Directory Specialty Listings

Dade County Medical Association

The Reference Committee moved that Resolution 77-26 be referred to the Board of Governors for consideration by the Judicial Council. A substitute motion was made from the floor to amend Resolution 77-26. The motion to amend was seconded and carried, and Resolution 77-26 as amended was adopted.

Resolution 77-26

Telephone Directory Specialty Listings

RESOLVED, That the FMA approve a listing in the specialty section of the yellow pages of "General Practice", with the notation following this listing: "See Family Practice".

The Chairman of Reference Committee III expressed his thanks to the members of the Committee, Doctors Kay Hanley, Joseph Harris, Franklin McKechnie, and Harold Yount. He also thanked those members of the Florida Medical Association who participated in the discussions. The Committee and the Chairman expressed its appreciation to their recording secretary, Mrs. Sandy Neel, for her fine work in preparing and helping to edit their report.

The motion of the Reference Committee that the report of Reference Committee No. III be adopted as amended carried.

Certificates of Appreciation

The Speaker resumed the Chair and asked Guy T. Selander, M.D. and John A. Rush, M.D. to escort James W. Walker, M.D. to the podium to receive the Certificate of Appreciation.

Certificate of Appreciation

James W. Walker, M.D.

WHEREAS, James William Walker, M.D., of Jacksonville, Florida has rendered distinguished and able service to the medical profession and citizenry of the State of Florida since 1954; and

WHEREAS, this dedicated physician was born in Cookeville, Tennessee, on August 16, 1927; attended Vanderbilt University, and was graduated from the University of Tennessee with an M.D. degree; and

WHEREAS, this eminent gentleman was associated with Duval Medical Center in Jacksonville, Florida from 1954 to 1956, and the Charity Hospital of Tulane University in New Orleans, Louisiana from 1957 to 1958; and served the Florida Medical Association as Secretary for five years and Treasurer for six years; and served the Florida Medical Foundation as Secretary-Treasurer for six years; and served as President and Chairman of the Judicial Committee of the Duval County Medical Society; and as a member of the American Medical Association Committee on Nursing; and

WHEREAS, Dr. Walker has served on the Board of Directors of Blue Shield of Florida, the Foundation for Medical Care in Duval County, and as an active member

of the National Joint Practice Commission; as a member of the Advisory Council of the Division of Vocational and Technical Education of Florida; and a member of the North East Florida Health Planning Council; and

WHEREAS, Dr. Walker has served on the Executive Advisory Council of E. R. Squibb & Sons, Incorporated and on the Medical Advisory Committee of the A. H. Robins Company; and as Secretary-Treasurer of Pedicraft Incorporated; as a member of the Board of Governors of the Chamber of Commerce, Jacksonville, Florida, and a member of the Board of Trustees of Jacksonville Children's Hospital; and

WHEREAS, Dr. Walker has served as a member of the Duval County Physicians for Better Government and has served as President and an active member of the Rotary Club of South Jacksonville, and as an Assistant Clinical Professor of Pediatrics of the University of Florida in Jacksonville; and

WHEREAS, Dr. Walker has served the Florida Medical Association as President of the Professional Insurance Management Company since December 1, 1975, therefore be it

RESOLVED, that a Certificate of Appreciation be presented to James William Walker, M.D., as a token of the warm appreciation that the officers, members and executive staff of the Association hold for the many years of outstanding service rendered by this fine gentleman.

Dr. Kahn asked Thomas E. McKell, M.D. and Richard G. Connar, M.D. to escort Donn L. Smith, M.D., to the podium to receive the Certificate of Appreciation.

Certificate of Appreciation Donn L. Smith, M.D.

WHEREAS, Donn Leroy Smith, Ph.D., M.D., of Tampa, Florida, has rendered distinguished and able service to the medical profession and citizenry of the State of Florida since 1970; and

WHEREAS, this dedicated physician was born in Denver, Colorado on November 1, 1915; attended Denver public schools and studied at the University of Denver and the

University of Colorado where he was awarded an M.D. degree; and

WHEREAS, this eminent educator was an Assistant Professor, Associate Professor, Assistant Dean, Associate Dean and Assistant to the Vice President for Medical Affairs at the University of Colorado, Dean and Professor of Physiology at the University of Louisville; Director of the Medical Center and Dean of the College of Medicine and Professor of Physiology at the University of South Florida; and

WHEREAS, this vigorous administrator has been an active member of the Kentucky Medical Association and the Jefferson (Kentucky) County Medical Society, the American Society for Pharmacology and Experimental Biology and Medicine, American Academy of General Practice, American Therapeutic Society, the Southern Medical Society and the Florida Medical Association and the American Medical Association; and

WHEREAS, Dr. Smith has been a member of the Research and Facilities Review Committee of the National Library of Medicine and is the author of numerous books and papers on medicine; therefore be it

RESOLVED, that a Certificate of Appreciation be presented to Donn Leroy Smith, Ph.D., M.D., as a token of the warm appreciation that the officers, members and executive staff of the Association hold for the years of outstanding service rendered by this fine gentleman.

Dr. MaCris gave a brief report on the reenactment of 1976 malpractice tort reforms, and an update concerning the status of the FMA PLI Legislative Program which was declared unconstitutional by a circuit court and is now being appealed before the State Supreme Court. He urged each delegate to contact his legislators asking them to support the Forbes Amendment to CS/SB 475 without further amendment.

The Second Meeting of the House of Delegates recessed at 5:30 p.m. to reconvene Sunday morning at 9:00 a.m.



No sooner had the House of Delegates adjourned than the new Board of Governors convened and got down to business. Seated, left to right: Treasurer Richard S. Hodes, M.D., Tampa; Secretary Robert E. Windom, M.D., Sarasota; Immediate Past President Jack A. MaCris, M.D., St. Petersburg; President Louls C. Murray, M.D., Orlando; President-Elect O. William Davenport, M.D., Miami; Vice President J. Lee Dockery, M.D., Gainesville; Past President Vernon B. Astler, M.D., Boynton Beach; and House Speaker Charles J. Kahn, M.D., Pensacola. Standing: Joseph G. Matthews, M.D., Orlando, Blue Shield of Florida; Norman M. Kenyon, M.D., Miami, District D; Joseph C. Von Thron, M.D., Cocoa Beach, AMA Delegate; Theodore J. Marshall, M.D., Pensacola, District A; Eugene G. Peek, Jr., M.D., Ocala, Department of Health and Rehabilitative Services; Benjamin M. Cole, M.D., Orlando, State Board of Medical Examiners; Thomas B. Thames, M.D., Orlando, District C; Donald G. Nikolaus, M.D., Dunedin, District B; Edward W. Stoner, M.D., Oviedo, At Large; and W. Harold Parham, D.H.A., Jacksonville, Executive Vice President.

Third House of Delegates

The third meeting of the House of Delegates convened at 9:00 a.m. on Sunday, May 8, 1977, in the Bal Masque Room of the Americana Hotel, Bal Harbour, Florida, with the Speaker of the House, Dr. Charles J. Kahn, presiding.

Dr. John Carlson, Chairman of the Credentials Committee reported 224 delegates were registered representing 39 societies, which constituted a quorum, and moved that the delegates be seated. The motion carried.

Delegates

ALACHUA—O. Frank Agee, M.D.; Thomas D. Bartley, M.D.; Daniel B. Cox, M.D.; William B. Deal, M.D.; D. O. Jenkins, M.D.; William W. Pfaff, M.D.; Gerold L. Schiebler, M.D.; James C. Campbell, Jr. (Student); (Absent - Mark V. Barrow, M.D.)

BAY—John F. Mason, Jr., M.D.; (Absent - Clark A. Whitehorn, M.D.)

BREVARD—Harold F. Albert, M.D.; William J. Broussard, M.D.; James E. Carter, M.D.; Michael J. Foley, M.D.; Laudie E. McHenry, M.D.; Burton Podnos, M.D.

BROWARD—Bruce B. Burgess, M.D.; Andre S. Capi, M.D.; Willis N. Dickens, M.D.; Burns A. Dobbins, M.D.; Arthur Eberly, M.D.; William C. Hartley, M.D.; Rupert S. Hughes, M.D.; David C. Lane, M.D.; George P. Messenger, M.D.; Ray E. Murphy, Jr., M.D.; Franklin B. Ott, M.D.; James B. Perry, M.D.; Thomas F. Regan, M.D.; Peter A. Tomasello, M.D.; Anthony J. Vento, M.D.; James C. Woulfe, M.D.; (Absent - Miles J. Bielek, M.D.; Robert J. Brennan, M.D.; Russell B. Carson, M.D.; Milton P. Caster, M.D.; Joseph E. Gelety, M.D.; Gary Gieseke, M.D.; John M. Harper, M.D.; Joseph M. Sachs, M.D.; Diran M. Seropian, M.D.; Juan S. A. Wester, M.D.)

CAPITAL—Robert P. Johnson, M.D.; Nelson H. Kraeft, M.D.; George N. Lewis, M.D.; Jack W. MacDonald, M.D.; Robert N. Webster, M.D.

CHARLOTTE—Melvyn J. Katzen, M.D.; (Absent - Fred P. Swing, M.D.)

CITRUS-HERNANDO—W. Randall Jenkins, M.D.; (Absent - William R. Lay, M.D.)

CLAY—Laurin G. Smith, M.D.

COLLIER—Fred A. Butler, M.D.; Edwin E. Dean, M.D.; Nicholas H. Kalvin, M.D.

COLUMBIA—Barney E. McRae, M.D.

DADE—Edward R. Annis, M.D.; Jose S. Bocles, M.D.; Rufus K. Broadaway, M.D.; Richard C. Clay, M.D.; Jack Q. Cleveland, M.D.; Vincent Corso, M.D.; O. William Davenport, M.D.; Joseph H. Davis, M.D.; Charles A. Dunn, M.D.; Franklin J. Evans, M.D.; Augusto Fernandez-Conde, M.D.; Miguel Figueroa, M.D.; Ivor Fix, M.D.; L. Marshall Goldstein, M.D.; Norman Gottlieb, M.D.; Leo Grossman, M.D.; Abraham Gurinsky, M.D.; Marshall F. Hall, M.D.; Henry C. Hardin, M.D.; Joseph Harris, M.D.; Norman M. Kenyon, M.D.; Maurice H. Laszlo, M.D.; Warren Lindau, M.D.; Carlos G. Llanes, M.D.; Rose E. London, M.D.; Miguel A. Mora, M.D.; Modesto M. Mora, M.D.; Harold G. Norman, M.D.; Joseph T. Ostroski, M.D.; Jorge R. Pena, M.D.; Raul V. Rivet-Arambula, M.D.; Walter M. Sackett, M.D.; Oscar S. Sandoval, M.D.;

Janice K. Sherwood, M.D.; Everett Shocket, M.D.; Chauncey M. Stone, M.D.; Mario Stone, M.D.; William M. Straight, M.D.; Charles F. Tate, M.D.; John C. Turner, M.D.; Edgar W. Webb, M.D.; Edmund Zahn, M.D.; Sheldon Zane, M.D.; (Absent - Emilio Aldereguia, M.D.; Hilario Anido, M.D.; Manuel L. Carbonell, M.D.; Isaac Egozi, M.D.; Richard M. Fleming, M.D.; Raul E. Galliano, M.D.; Pedro J. Greer, M.D.; Julian H. Groff, M.D.; Walter C. Jones, II, M.D.; James R. Jude, M.D.; Herbert S. Kaiser, M.D.; Banning G. Lary, M.D.; Milton E. Lesser, M.D.; Charles A. Monnin, M.D.; Thomas J. Noto, M.D.; Victor A. Politano, M.D.; Pedro A. Ramos, M.D.; Arvey I. Rpgers, M.D.; Philip Samet, M.D.; Edward W. St. Mary, M.D.; Samuel P. Stokley, M.D.; Shreve M. Archer, Student)

DESOTO-HARDEE-GLADES—Calvin W. Martin, M.D.

DUVAL—James L. Borland, M.D.; William P. Booras, M.D.; Yank D. Coble, M.D.; Wilbert L. Dawkins, M.D.; Thomas S. Edwards, M.D.; Charleas P. Hayes, Jr., M.D.; H. Joseph Hurlbut, M.D.; Walter C. Jarrell, M.D.; John C. Kruse, M.D.; Charles B. McIntosh, M.D.; Faris S. Monsour, M.D.; Daniel B. Nunn, M.D.; William L. Pearce, M.D.; B. Craig Ray, M.D.; John A. Rush, M.D.; Guy T. Selander, M.D.; Robert H. Threlkel, M.D.; William D. Walklett, M.D.

ESCAMBIA—William Reed Bell, M.D.; George L. Carr, M.D.; Eric F. Geiger, M.D.; Theodore J. Marshall, M.D.; John H. Whitcomb, M.D.; (Absent - Charles F. McConnell, M.D.)

FRANKLIN-GULF—(Absent - Joseph P. Hendrix, M.D.)

HIGHLANDS—Donald C. Hartwell, M.D.; (Absent - Glenn V. Hough, M.D.)

HILLSBOROUGH—Francis C. Coleman, M.D.; Richard G. Connar, M.D.; Robert J. Courtney, M.D.; Irving M. Essrig, M.D.; John C. Fletcher, M.D.; J. Carlisle Hewitt, M.D.; Richard S. Hodes, M.D.; Victor H. Knight, Jr., M.D.; Joel W. Mattison, M.D.; Thomas E. McKell, M.D.; Lawrence Muroff, M.D.; John K. Petrakis, M.D.; Ralph E. Rydell, M.D.; Ralph M. Stephan, M.D.; William W. Trice, M.D.; Harold L. Williamson, M.D.;

INDIAN RIVER—Ferdinand F. Becker, M.D.; (Absent - Donald L. Ames, M.D.)

LAKE—Fred C. Andrews, M.D.; Thomas D. Weaver, M.D.; Ernest Wollin M.D.

LEE—Larry P. Garrett, M.D.; Francis L. Howington, M.D.; H. Quillian Jones, Jr., M.D.; Marcus M. Moore, M.D.; (Absent - John S. Hagen, M.D.)

MADISON—(Absent - Julian M. Durant, M.D.)

MANATEE—Anthony Cuva, M.D.; Robert King, M.D.; Roger A. Meyer, M.D.; (Absent - John D. Lehman, M.D.)

MARION—C. Brooks Henderson, M.D.; Samuel L. Renfroe, M.D.

MARTIN—Richard O. Penick, M.D.; John F. Powers, M.D.

MONROE—(Absent - Ronald H. Chase, M.D.; Lancelot Lester, Jr., M.D.)

NASSAU—Jose Luis Castillo, M.D.

OKALOOSA—William W. Thompson, M.D.; Eugene R. Valentine, M.D.

ORANGE—Clarence C. Bailey, M.D.; Manuel J. Coto, M.D.; Sam F. Elder, M.D.; Edward L. Farrar, M.D.; Clarence M. Gilbert, M.D.; Allen K. Holcomb, M.D.; Rufus M. Holloway, M.D.; Donald V. Jablonski, M.D.; Franklin B. McKechnie, M.D.; G. Brock Magruder, M.D.; James F. Richards, Jr., M.D.; James J. Schoeck, M.D.; Edward W. Stoner, M.D.; T. Byron Thames, M.D.; Robert B. Trumbo, M.D.

OSCEOLA—George Albert Gant, M.D.

THIRD HOUSE OF DELEGATES

PALM BEACH—Vernon B. Astler, M.D.; John D. Corbitt, Jr., M.D.; Jerry F. Cox, M.D.; James Russell Forlaw, M.D.; Luis Guerrero, M.D.; Bernard Kimmel, M.D.; Doris E. Lake, M.D.; Charles E. Metzger, M.D.; Richard Benjamin Moore, M.D.; Thomas E. Murphy, M.D.; Reginald J. Stambaugh, M.D.; Arthur L. Trask, M.D.; Dick L. Van Eldik, M.D.; Harold A. Yount, M.D.

PANHANDLE—Herbert E. Brooks, M.D.; William F. Brunner, M.D.

PASCO—D. L. Deal, M.D.; Nesson McCann, M.D.

PINELLAS—Emil Eddy Burns, M.D.; Thomas M. Daniel, M.D.; Charles K. Donegan, M.D.; John M. Hamilton, M.D.; Walter W. Hamilton, M.D.; Kay Knight Hanley, M.D.; Daniel S. Hellman, M.D.; David S. Hubbell, M.D.; Morris J. LeVine, M.D.; Jack A. MaCris, M.D.; William F. Mallette, M.D.; James Hugh Miller, M.D.; James M. Neill, M.D.; Donald G. Nikolaus, M.D.; David T. Overbey, M.D.; Walter H. Winchester, M.D.

POLK—Thomas M. Caswall, M.D.; Clyde E. Gibson, M.D.; John W. Goltfelty, M.D.; Robert B. Peddy, M.D.; C. Russell Smith, M.D.; Paul A. Tanner, Jr., M.D.; Luther A. Youngs, III, M.D.; Frank Zeller, Jr., M.D.

PUTNAM—Roy E. Campbell, M.D.

ST. JOHNS—William W. O'Connell, M.D.; (Absent - James J. DeVito, M.D.)

ST. LUCIE-OKEECHOBEE—Howard C. McDermid, M.D.; William H. Meyer, Jr., M.D.

SANTA ROSA—(Absent - William N. Watson, M.D.)

SARASOTA—John N. Carlson, M.D.; Kenneth C. Kiehl, M.D.; Douglas R. Murphy, M.D.; Franklin Pfeifferberger, M.D.; Richard C. Rehmyer, M.D.; Karl R. Rolls, M.D.

SEMINOLE—Luis M. Perez, M.D.; Maria P. Perez, M.D.

SUWANEE-HAMILTON-LAFAYETTE—Laurent V. Radkins, M.D.

TAYLOR—John H. Parker, M.D.

VOLUSIA—Richard L. Dillard, M.D.; Michael H. Fronstin, M.D.; Irwin Leider, M.D.; Richard W. Snodgrass, M.D.; James G. White, M.D.; (Absent - Octavius B. Bonner, M.D.)

WALTON—(Absent - Howard F. Currie, M.D.)

SPEAKER OF THE HOUSE—Charles J. Kahn, M.D.

VICE SPEAKER—Sanford A. Mullen, M.D.

Dr. Kahn recognized the President, Dr. Jack A. MaCris. Dr. MaCris asked the House to express its appreciation to Dr. Harold Parham and Don Jones, and the FMA staff, for the success and efficiency of the meeting.

Dr. MaCris then introduced his family; his associate, Dr. John Lee and his wife Naomi; and his secretary, Barbara Yost.



Retiring President Jack A. MaCris, M.D., presents the gavel (left picture) to his successor, Louis C. Murray, M.D. Dr. Murray prepares to present Dr. MaCris with his Past President's pin (right).

THIRD HOUSE OF DELEGATES

Dr. MaCris presented the personal gavel and President's certificate to Dr. Murray, the new President.

Dr. Murray presented Dr. MaCris with the Past President's pin.

Dr. Murray accepted the gavel with pleasure and stated that Dr. MaCris had left the Association in good order. He stated that he accepted the challenges of the coming year with a great deal of confidence in the solidarity, loyalty, and dedication of the membership of the Florida Medical Association; confidence in the ability and judgment of the House of Delegates to give us the policy to work with; and confidence in the Board of Governors to help carry it out.

Dr. Murray then introduced his family with a special tribute to his wife, Sue, on this Mother's Day.

The President then asked Stephen MaCris to escort his mother, Janet, to the podium where he presented her with Dr. MaCris' portrait.

The Vice Speaker resumed the Chair and called for the report of Reference Committee IV.



Retiring FMA President Jack A. MaCris, M.D., St. Petersburg, and Mrs. MaCris.



New FMA President Louis C. Murray, M.D., of Orlando, and Mrs. Murray.

Report of Reference Committee No. IV

Legislation and Miscellaneous

Dr. John Rush, Chairman, and the members of Reference Committee No. IV, came forward to present the report of Reference Committee No. IV, Legislation and Miscellaneous.

Report of the Council on Legislation and Regulations

The motion of the Reference Committee that the report of the Council on Legislation and Regulations be adopted as printed in the handbook carried.

Council on Legislation and Regulations

James B. Perry, M.D., Chairman

Most of the work of the Council on Legislation and Regulations is accomplished through activities of its two committees: the Committee on State Legislation and the Committee on National Legislation. The report of your Council is submitted as individual reports of the two major committees.

Committee on National Legislation — This committee consists of the key contact physicians for each member of the Florida delegation of the U.S. Senate and the U.S. House of Representatives. Members of this committee have kept in close touch with their assigned Senators and Congressmen on national legislative matters of interest to the FMA and American Medical Association.

The Association has reestablished its format of previous years for congressional visitation. The 1977 visitation will be carried out March 23 and 24 with briefings by the AMA Washington Office and visits to each congressman, con-

cluding with a delegation luncheon in the Speaker's Dining Room. Individual visits will be scheduled in the future on an "as needed" basis.

The major legislative project of the committee during the coming year will continue to be one of monitoring the national health insurance situation and developing a mechanism for implementation of any congressional contact action that might be needed.

Committee on State Legislation—The committee has had another active year with responsibilities for coordinating all state legislation for the Florida Medical Association and recognized specialty groups. Five formal meetings of the committee have been held, along with informal conferences among committee members as items of an urgent nature arose.

Consistent with the policies developed by the FMA House of Delegates the committee has worked closely with the Board of Governors in developing our legislative program for the 1977 session of the Florida Legislature.

During the past year, several county medical society executives came to Tallahassee during the period while the Legislature was in session, and this proved to be most helpful to the Capital Office in getting legislative support from the larger metropolitan areas. The committee intends to encourage this same procedure during the coming year.

The following items summarize the committee's activities:

1. The Capital Office is continuing to function under the supervision of Donald S. Fraser Jr., Director of the Legislative Affairs Department of the FMA. He has been materially assisted by George Palmer Jr., Manager of the Capital Office, who has greatly increased the capacities of the Association to maintain close coordination with the county medical societies on legislative activities. Mrs.



John A. Rush, M.D., Jacksonville (standing) chaired Reference Committee IV, which heard testimony on the FMA legislative program. Others (left to right): Richard C. Clay, M.D., Miami; Herbert E. Brooks, M.D., Bonifay; Mrs. Nancy Hendricks, Hilliard, Recorder; George P. Messenger, M.D.; Ft. Lauderdale; and John M. Hamilton, M.D., St. Petersburg.

Nancy Moreau continues to give the Capital Office the capacity to do independent analysis and research on the more important legislative matters being considered. Continuing emphasis is being placed on using the resources of the Capital Office to provide better services and coordination for the medical specialty groups.

2. The Capitol Dispensary—The committee has continued to place major emphasis on the working with the Capitol Dispensary which has proven to be most important in meeting the needs of legislators and their staffs. Mrs. Delma Hart, R.N., has continued to provide excellent assistance to the FMA in coordinating the activities of the Dispensary for the Doctor of the Day Program.

3. The Committee on State Legislation is continuing to emphasize the need to develop a good key contact physician program in each county medical society in the state. A program has been undertaken to work with each county medical society in reviewing their assigned key contact physicians to make sure that the best possible physician is assigned this critical task.

4. Publications—A legislative bulletin was published every week during the legislative session and periodically between sessions. The bulletin is designed to give up-to-date information to members of the FMA who are involved in legislative activities. A special publication has been instituted to communicate with members of the FMA on the current status of the Priority '77 legislative effort. This special publication will be mailed on a regular basis in addition to the legislative bulletin.

5. 1976 Legislative Accomplishments—During the 1976 legislative session, there were more than 300 legislative proposals that required action by the state legislative committee or the Capital Office staff. Matters of major interest to the Florida Medical Association were:

—Passage of an omnibus bill on professional liability.

The provisions advocated by the FMA were:

- a. Structured payout of future damages
- b. Definition of professional negligence
- c. Application of collateral sources in jury trials as a direct offset
- d. Definition of medical expert witness
- e. Prohibit use of res ipsa loquitur doctrine in professional negligence actions
- f. Remittitur-additur provision

—Defeat of legislation to give limited hospital privileges to chiropractors (HB 3223)

—Defeat of legislation to establish a Health Care Cost Commission (HB 3951)

—Defeat of legislation requiring certificate of need for equipment in a physician's office (SB 1365)

—Defeat of legislation to place consumer on SBME (HB 995)

—Passage of requirement for insurance companies to cover mental and nervous disorders on an optional basis (SB 98)

—Defeat of legislation to mandate "Fifth Pathway" in all Florida medical schools (HB 2546)

—Defeat of legislation to require submission of itemized bill, understandable in laymen's terms, to patient within 14 days of treatment (HB 3375)

6. Major legislative objectives for the 1977 Session—The major legislative objectives for the 1977 Session of the Florida Legislature as established by the FMA House of Delegates and the Board of Governors were:

—Reenactment of 1976 Tort Reforms that were declared unconstitutional by Leon County Circuit Court. Such reforms are:

- a. Structured pay-out of future damages (The Senate-House Conference Committee amended this provision for structured pay-outs only when damages exceed \$200,000)
- b. Definition of medical professional negligence
- c. Application of collateral sources in jury trials, as a direct offset
- d. Definition of medical expert witnesses
- e. Prohibit use of res ipsa loquitur doctrine in professional negligence actions

f. A remittitur-additur provision which provides for the judge to lower or raise an award, if, in his opinion, the jury verdict is excessive or inadequate

—Establishment of an absolute two year statute of limitations

—Provision for recovery of defense costs in medical malpractice cases

—Legislation to create a separate Department of Health headed by an M.D. or Osteopath with Cabinet rank

—Necessary funding to establish reasonable fee schedule for Medicaid and to implement a PMUR contract for Medicaid

—Legislation to prevent use of drugs by optometrists

—Legislation to require physician supervision of EMTs

—Defeat legislation to require certificate of need for equipment in physician's office

—Defeat legislation to grant limited hospital privileges to chiropractors

—Defeat of measures to weaken present licensure procedures for physicians desiring to practice in Florida

—Defeat of legislation to establish State Hospital and Nursing Home Cost Commission

A supplemental report will be prepared by the committee on State Legislation and distributed prior to the first session of the House of Delegates. This supplemental report will outline up-to-date progress of the FMA legislative program made during the 1977 Legislative Session. It will also include other important state legislative items which might develop prior to the FMA Annual Meeting.

Supplemental Report

Council on Legislation and Regulations

The Reference Committee had heard a report from Doctor James Perry, Chairman of the Council on Legislation and Regulations, concerning the status of legislation as of May 5, 1977. The Committee expressed its appreciation to Doctor Perry for his excellent and well organized report, and applauded him and the state and national legislative committees for their services to this Association and to Florida's citizens during the past year.

The motion of the Reference Committee that the supplemental report of the Council on Legislation and Regulations be adopted as printed carried.

Supplemental Report

Council on Legislation and Regulations

This is to update the report of the Council on Legislation and Regulations printed in the Delegates handbook. This report reflects the status of legislation as of April 27, 1977.

LEGISLATIVE STATUS OF FMA 1977 LEGISLATIVE PROGRAM

1. Professional Liability Legislative Program

As of the date of this report, the Senate has on the Calendar legislation, SB 837, which will re-enact the 1976 malpractice tort reforms. On the House Calendar is a committee bill by the House Commerce Committee, HB 2188, which accomplishes the same objective. Contained in this package are the following items:

- a. Application of collateral sources in jury trials, as a direct offset.

- b. Definition of medical professional negligence.
- c. Definition of medical expert witnesses.
- d. Prohibit use of res ipsa loquitur doctrine in professional negligence actions.
- e. Structured pay-out of future damages (the Senate Conference Committee amended this provision for structured pay-outs only when damages exceed \$200,000).
- f. A Remittitur-Additur provision which provides for the Judge to lower or raise an award if, in his opinion, the jury verdict is excessive or inadequate.

The House Commerce Committee bill has been changed from the 1976 version in that it does not allow an offset for future collateral source benefits. The Association is actively working to get this provision changed. On the Senate Calendar also is legislation, CSSB 475, which ties the 1976 tort reforms in with a revision of the risk management provisions from the 1976 law (MacKay Plan).

The 1977 priority professional liability legislative issues have been filed in the House and the Senate. These bills are:

- a. Absolute 2 year statute of limitations (HB 1643, SB 1361).
- b. Recovery of defense costs (HB 1809, SB 1401).

2. Separate Department of Health with Cabinet Rank
Legislation has been filed in both the House and Senate which would revise Florida's constitution to establish a separate Department of Health headed by a Secretary of Cabinet rank. The House Bill, HB 2088, has been referred to the Committee on Governmental Operations and Appropriations. The Senate Bill, SB 991, has been referred to HRS, Governmental Operations, and Rules.

3. Status of Other Issues of Concern to Florida Physicians

a. Revision of Florida's emergency medical services act to include certification of paramedics and advanced support life system equipment (HB 1598). Referred to HRS and the Senate companion, SB 1011, has been referred to HRS and Judiciary-Criminal.

b. Certificate of need for selected items of equipment in physicians' offices. The proposed House Committee bill has been amended to delete any reference to items of equipment in physicians' offices. It is still in HRS. The Senate companion, SB 1112, has been referred to HRS and Commerce. This bill does require certificate of need for selected items of equipment in physicians' offices.

c. Limited hospital privileges for chiropractors, HB 559. This legislation has been referred to HRS.

d. Consumers on the State Board of Medical Examiners. Several bills have been filed in both the House and Senate which would require consumers be placed on the State Board of Medical Examiners. As of this date, none of these have been voted out by Committees.

e. Standardized health claim forms. The Senate has passed a bill, SB 6, which would require standardized health claim forms to be accepted by insurers and the Department of HRS. This bill is now on the House Calendar.

f. Geriatric nurse outpatient clinics (HB 349) has been referred to the Mental Health and Health Subcommittee of the HRS Committee.

g. Licensure of radiologic technologists (HB 689, SB 591). The House bill has been referred to Regulated Industries, Finance and Taxation, and Appropriations and the Senate Bill has been referred to HRS and Appropriations.

h. Laetrile. The House Bill, HB 768, is on the House Calendar and the Senate bill, SB 478, is on the Senate Calendar.

i. Truth in sickness (HB 1941). This legislation which would require extensive reporting by physicians who have ownership in any health care facility or pharmaceutical company, has been referred to the House Committee on HRS.

j. Pap smears (SB 431). This legislation which would require all primary care physicians to offer pap smears to patients 20 years of age and older and maintain extensive records on same is in the Senate Commerce Committee.

k. \$100 tax on M.D.'s to subsidize practices in areas of need (SB 530), is in Senate HRS Committee.

OTHER LATE DEVELOPING LEGISLATIVE ACTIVITIES

The Council would ask for permission to introduce to the reference committee any item of major significance that might have arisen in the Legislature between April 27 and the time of the FMA meeting.

Testimony was brought out before the Reference Committee informing it of the Constitutional Revision Commission and its importance.

The motion of the Reference Committee that whatever action is necessary be taken on behalf of the Florida Medical Association to assist and cooperate with the Constitutional Revision Commission of the State of Florida carried.

BOARD OF GOVERNORS REPORT

Referrals by House of Delegates: Death with Dignity Recommendation No. 2

The Reference Committee moved that the third paragraph of Recommendation No. 2 be deleted and that the words "and further" be substituted. A motion from the floor to amend the substitute failed and the motion of the Reference Committee carried. (See Report of Board of Governors, Page 442).

**Board Actions: No. 17
Professional Liability Insurance**

The motion of the Reference Committee that the Board's report on Professional Liability Insurance be adopted as printed in the handbook carried. (See Report of Board of Governors, Page 445).

**FMA Councils and Committees
Council on Legislation and Regulations**

Florida Academy of Trial Lawyers

The motion of the Reference Committee that the Board's Report on the Florida Academy of trial lawyers be adopted as printed in the handbook carried. (See Report of Board of Governors, Page 446).

Procedures to be Followed by Specialty Groups in Developing Legislative Objectives

The motion of the Reference Committee that the Board's Report on the procedures to be followed by specialty groups in developing legislative objec-

tives be adopted as printed in the handbook carried. (See Report of Board of Governors, Page 447).

1977 Florida Legislative Session

The motion of the Reference Committee that the Board's Report on the 1977 Florida Legislative Session be adopted as printed in the handbook carried. (See Report of Board of Governors, Page 447).

Certificate of Need

The motion of the Reference Committee that the Board's Report on the Certificate of Need be adopted as printed in the handbook carried. (See Report of Board of Governors, Page 447).

Medicaid

The motion of the Reference Committee that the Board's Report on Medicaid be adopted as printed in the handbook carried. (See Report of Board of Governors, Page 447).

Nuclear Medical Technologists

The motion of the Reference Committee that the Board's report on Nuclear Medical Technologists be adopted as printed in the handbook carried. (See Report of Board of Governors, Page 447).

National Health Insurance

The Reference Committee moved that the Board's Report on National Health Insurance be adopted as printed in the handbook. A substitute for the Board of Governors report was moved.

After much discussion, the substitute carried by a vote of 119 to 93. (See Report of Board of Governors, Page 447).

Specialty Group Letter Agreements

The motion of the Reference Committee that the Board's Report on Specialty Group Letter agreements be adopted as printed in the handbook carried. (See Report of Board of Governors, Page 447).

Resolution 77-1

Drug Substitution

Okaloosa County Medical Society

The Reference Committee presented a substitute resolution for Resolution 77-1. A motion from the floor was made to amend the substitution. The motion of the Reference Committee that Substitute Resolution 77-1, Drug Substitution, be adopted as amended carried.

Resolution 77-1 Drug Substitution

RESOLVED, That the officers, Board of Governors, Committees, members and employees of the Florida Medical Association be directed to use their offices to implement legislative action as deemed necessary to require generic drug houses to justify the equivalency—biological, safety, and effectiveness—rather than using a negative formulary, and be it further

RESOLVED, That legislative action be taken so that prescription blanks have appropriate wording printed thereon so that instructions for substitution or non-substitution can be indicated by the physician, and that the requirement for the words "medically necessary" be stricken from the existing law, and be it further

RESOLVED, That the Florida Medical Association enlist the support of the Florida Pharmaceutical Association to this end.

Resolution 77-7 Cardiopulmonary Resuscitation Palm Beach

The motion of the Reference Committee that Resolution 77-7, Cardiopulmonary Resuscitation, be adopted as printed in the handbook and that implementation of this resolution should receive high priority carried.

Resolution 77-7 Cardiopulmonary Resuscitation

RESOLVED, The Florida Medical Association, through the appropriate channels, urge the Florida Legislature to extend the "Good Samaritan Law" to include physicians who are summoned to perform and become involved in the care of patients during cardiopulmonary resuscitation.

Resolution 77-11 Board of Medical Examiners Lee County

The Reference Committee presented a substitute for Resolution 77-11. The motion of the Reference Committee that substitute resolution 77-11, Board of Medical Examiners, be adopted carried.

Resolution 77-11 Board of Medical Examiners

RESOLVED, That FMA give high priority and seek legislative action to permit the Florida Board of Medical Examiners to summarily suspend a license of a physician upon finding that said physician had engaged in reckless and/or gross misconduct in the practice of medicine, pending the exercise of the right of the physician to a speedy hearing on the merits.

RESOLVED, That FMA seek legislative relief to give the Board of Medical Examiners resources to investigate and bring to a speedy hearing physicians who have been charged with violations of the Medical Practice Act.

RESOLVED, That FMA seek legislative relief to provide the necessary and adequate funds for the Board of Medical Examiners to carry out their responsibilities under the Medical Practice Act, and further be it

RESOLVED, That FMA work to improve communications between the FMA Judicial Council, the local component county medical societies, and the Florida State Board of Medical Examiners.

Resolution 77-20

**Health Professions Data Reporting System
Hillsborough County Medical Association**

The Reference Committee offered a substitute for Resolution 77-20. The motion of the Reference Committee that Substitute Resolution 77-20, Health Professions Data Reporting System, be adopted carried.

Resolution 77-20

Health Professions Data Reporting System

RESOLVED, That the House of Delegates of the FMA ask the elected representatives in Congress from the State

of Florida to seek alteration of Section 708 of PL 94-484 which singles out one specific group for invasion of privacy, and further be it,

RESOLVED, That this resolution be presented to the AMA by the Florida AMA Delegates to enlist the assistance of AMA in opposing or altering this provision of the Law.

The Chairman thanked the members of the Committee: Herbert E. Brooks, M.D.; Richard Clay, M.D.; John Hamilton, M.D.; and George P. Messenger, M.D.; the members who came to speak before the Committee; and Mrs. Nancy Hendricks, who served as the secretary for the Committee. He stated that without the efforts, assistance, and cooperation of all the above, this report would not have been possible.

The motion of the Reference Committee that the Report of Reference Committee IV be adopted as amended carried.



The new President-Elect, O. William Davenport, M.D., of Miami, (center) is escorted to the dais by Joseph H. Davls, M.D., Miami (left), and Jack Q. Cleveland, M.D., Coral Gables.



House Speaker Charles J. Kahn, M.D., Pensacola, welcomes O. William Davenport, M.D., (right), Miami, to the dais as FMA's new President-Elect. Dr. Davenport, formerly Vice President, was elected without opposition.

Report of Reference Committee No. V

Medical Economics

The Speaker, Dr. Kahn, called for the report of Reference Committee No. V, Medical Economics.

Dr. Francis C. Coleman, Chairman, and members of the Reference Committee came forward to present the report of Reference Committee No. V.

Report of Council on Medical Economics

"Mr. Speaker, your Reference Committee was impressed with the productive efforts of the Council on Medical Economics, chaired by James F. Richards, Jr., M.D. The Committee noted particularly the effort to obtain an increase in the HRS Fee Schedule and urges the Council to continue this effort. The Committee was pleased to note a 32% across-the-board increase in the Workmen's Compensation fee schedule that became effective March 1, 1976. Your Reference Committee also noted the continued activity on Relative Value Studies and wishes to point out the timeliness of this effort in view of the anticipated inclusion of a section in the 1977 Medicare/Medicaid Reform Bill, to be sponsored by Senator Herman Talmadge, authorizing the continuation of Relative Value Studies. If enacted, this provision would nullify efforts of the Federal Trade Commission and the Justice Department to eliminate relative value studies."

The motion of the Reference Committee that the report of the Council on Medical Economics be adopted carried.

Council on Medical Economics

James F. Richards, Jr., M.D., Chairman

The Council on Medical Economics activity in 1976-77 required no meetings of the Council. The activities of the Council were conducted by the Chairman with assistance from the executive staff. Involvement included the Department of Health and Rehabilitative Services Fee Schedule and the Workmen's Compensation Program. With the appointment of a Special Committee on the Cost of Medical Care, this function was removed from the Council on Medical Economics.

Department of HRS Fee Schedule — In May 1976, the Department of HRS established a task force to review its medical and surgical fee schedule which resulted in meetings in Tallahassee on June 17, June 24, June 30, July 8-9, and July 20, 1976. The essential results of the task force's recommendations were that the 1975 Relative Value Studies be used as the basis for the Department's fee schedule; that an interim increase to the 60th percentile be implemented on January 1, 1977; an increase to the 75th percentile be implemented on July 1, 1977; and the fee schedule be reviewed annually. Because of budget limitations, these recommendations have never been implemented; however, the Council has continued efforts to have the fee schedule updated. These efforts have included meeting with representatives of the Department of HRS as well as members of the House and Senate HRS Committees and their staff. Hopefully, an update in the fee schedule will be implemented, effective July 1, 1977, with the addition of various management systems within the Department of HRS to increase the efficiency of the Department's operations.

Workmen's Compensation — Culminating with a third public hearing in December, 1975, a 32% across-the-board increase was granted in the Workmen's Compensation Medical and Surgical Fee Schedule which was effective on March 1, 1976. As a result of the FMA's activity in seeking an update of the Fee Schedule, James F. Richards, M.D., was appointed to serve on the Advisory Council to the Bureau of Workmen's Compensation. It is hoped that through our representation on this Council many improve-



Reports and resolutions in the area of Medical Economics were aired before Reference Committee V and its Chairman, Francis C. Coleman, M.D., Tampa (standing). Others (left to right): Warren Lindau, M.D., Miami; Andre S. Capl, M.D., Ft. Lauderdale; Ms. Marcia Protheroe, Jacksonville, Recorder; Charles F. McConnell, M.D., Pensacola; and John H. Parker Jr., M.D., Perry.

ments on the Workmen's Compensation Program will be forthcoming. Through the Advisory Council, we have obtained endorsement in recognizing different levels of office and hospital visits which will be reflected in the next update of the Medical and Surgical Fee Schedule.

In December 1976, a meeting was held with Mr. Steven Campora, Director of the Department of Commerce. At this meeting, Mr. Campora informed us that the Department's budget request included funds for hiring medical consultants to assist in evaluating unusual Workmen's Compensation claims and funds to implement a computer system capable of developing fee profiles which would greatly facilitate future determinations of Fee Schedule increases. Future meetings are planned with the Florida Osteopathic Medical Association, Associated Industries and others to prepare our request for the 1977 annual increase in the Fee Schedule.

Committee on Relative Value Studies — Even though the 1975 Florida Relative Value Studies was published in early 1976, the Committee on Relative Value Studies continues to be the most active Committee of the Council. Meetings were held in Tampa on August 28, 1976, November 6, 1976, and December 18, 1976, with one telephone conference held on September 29, 1976. An additional meeting of the committee is planned for April 9, 1977.

Much of the committee's efforts during the past year have been in attempting to resolve the problem of relative values for anesthesiologists who supervise nurse anesthetists under their employ. After it was clarified that the basic purpose of the Relative Value Studies is to determine relative values for services and procedures performed by licensed physicians and is not intended for use by nurse anesthetists or other paramedical personnel, the problem was resolved to the satisfaction of the anesthesiologists. The committee also reviewed many other inquiries and questions regarding the 1975 RVS.

The committee met jointly with the Council on Specialty Medicine on August 28, 1976, to explain the 1975 RVS. As a result of this meeting, it is hoped that an open line of communication with recognized specialty groups can be maintained. Each representative on the Council on Specialty Medicine is informed of meetings of the committee and many have taken advantage of the opportunity to meet with the committee to discuss various issues.

The committee is presently undertaking the major task of comparing the recently published **Current Procedural Terminology Fourth Edition** with the **1975 Relative Value Studies** to evaluate the differences in the coding and nomenclature between the two publications. This comparative analysis will be evaluated at the meeting on April 9, 1977.

Committee on Health Insurance — Because of direct communication between the FMA and Blue Shield at the Board level, the activity of the Committee on Health Insurance was kept to a minimum. Through staff, the committee has continued to maintain communication with the Health Insurance Association of America which represents about 90% of the health insurance industry. No major problems were referred to the committee; therefore, it was not necessary for the committee to meet during the past year.

Realizing that much of the work in the area of medical economics must be done on an individual basis through negotiations with such parties as the Department of HRS and the Department of Commerce, the Council would like to thank those members of the FMA who gave of their time at the request of the Council and contributed to the FMA's efforts in the area of medical economics.

Council on Medical Systems

"Mr. Speaker, your Reference Committee reviewed the report of the Council on Medical Systems, Chaired by James L. Borland, Jr. M.D. This Council has continued its efforts to improve peer medical

utilization review and has sponsored several active meetings on this subject. These efforts were recently recognized in a study of the cost effectiveness of peer review for the Bureau of Health Insurance.

"This report contained the following statement: 'The benefits of peer review appear to substantially outweigh its costs in Florida and benefits due to the deterrent effect of peer review are strongly evident in all peer review areas considered.'

"The Council was instrumental in the development of the Florida Health Data Corporation, Inc. The Council is also carefully monitoring the litigation against the Department of HEW with respect to PL 93-641."

The motion of the reference committee that the report of the Council on Medical Systems be adopted carried.

Council on Medical Systems

James L. Borland, Jr., M.D., Chairman

The Council on Medical Systems had a very active year involving such items as cost containment legislation, PSRO's, Department of HEW utilization review regulations, Medicaid, including negotiations for a peer review contract, health planning including monitoring HSA activity and the State Health Coordinating Council and the Florida Health Data Corporation, Inc. The Council held meetings on August 7, 1976, January 27, 1977, as well as a telephone conference on January 5, 1977, and has an additional telephone conference scheduled for March 14, 1977.

The Committee on Peer Medical Utilization Review was very active with meetings held May 1-2, 1976, October 2-3, 1976, and February 12-13, 1977. Additionally, a two-day meeting is scheduled immediately prior to the 1977 Annual Meeting. In addition to retrospective peer review for Medicare, the committee conducts health insurance claim reviews as well as psychiatric claim reviews under the Florida Medical Insurance Trust. During the past year the committee has reviewed 75 PMUR cases and 26 health insurance appeals.

Activities of this committee were highly praised in a recent study of cost effectiveness of peer review for the Bureau of Health Insurance by the College of Industrial Management at the Georgia Institute of Technology. The study concluded that "The benefits of peer review appear to substantially outweigh its costs in Florida and benefits due to the deterrent effect of peer review are strongly evident in all peer review areas considered."

The committee also developed procedures for peer medical utilization review of cases referred by Group Health Inc., and expressed protest to CHAMPUS that individuals other than physicians are doing medical peer review for psychiatric benefits under the CHAMPUS Program.

The chairman and staff have been involved in negotiations to establish a peer review system for the Medicaid Program. This has included meeting with representatives of the Department of HRS as well as testifying before the House of Representatives Committee on HRS.

The Committee on Foundations for Medical Care and PRO evaluated by actual site survey many of the existing computer programs designed to support medical peer review. Also, the committee has continued to monitor the development of local PSRO's in the State.

Two years of investigation into health care data systems has culminated with the formulation of the Florida Health Data Corporation, Inc. This corporation is com-

prised of four representatives of the FMA, four representatives of the Florida Hospital Association, and one representative of the Florida Osteopathic Medical Association. The corporation is presently developing a proposal to contract with the State of Florida to collect data on adverse medical incidents required by the professional liability legislation passed in 1976. Additionally, the corporation is reviewing the requirements for data collection by Health Service Areas and Professional Standard Review Organizations.

The Committee on Government Programs through the chairman and staff have carefully monitored the activities of health planning under PL 93-641, implementation of the State Health Coordinating Council, and development of the Health Systems Agencies.

The Council reviewed the lawsuit of the North Carolina Medical Society, the AMA, the State of North Carolina, the State of Missouri and the Louisiana State Medical Society against the Department of HEW and PL 93-641. Advised by legal counsel that the legal issues are being attacked adequately by counsel representing the plaintiffs, the Council on Medical Systems reiterated its position against the interference into the practice of medicine imposed by PL 93-641.

BOARD OF GOVERNORS REPORT

Referrals By House of Delegates

1975 RVS Reduced Anesthesia Value for Supervision Recommendation No. 3

The motion of the Reference Committee that the Report on 1975 RVS Reduced Anesthesia Value for Supervision and Recommendation No. 3 of the Board of Governors be adopted carried. (See Report of the Board of Governors, Page 442).

Resolutions 76-12 and 76-22

These Resolutions has been referred to the Board of Governors and a report on them was made in Orlando on January 28, 1977. A policy statement on mandatory insurance had been adopted by the House of Delegates. The chairman stated that no further action by this House is required.

The motion of the Reference Committee that the Board's Report on Resolution 76-12 and 76-22 be adopted carried. (See Report of the Board of Governors, Page 442).

Resolution 76-20

Professional Review Organization Recommendation No. 4

This Resolution had been introduced at the Annual Meeting of the Florida Medical Association in 1976. It had not been adopted but the House did refer that portion of the Reference Committee's report to the Board of Governors which requested an opinion from the Speaker of the House and the Judicial Council as to whether 50% of the approved mandate specifically relates only to component county medical societies of the Florida Medical Association.

Recommendation No. 4 of the Board of Governors reaffirms previous policy of the House of Delegates with respect to PSRO and recommends that Resolution 76-20 not be adopted.

No testimony was presented to your Reference Committee on this recommendation. Your Reference Committee is aware, however, of activity in several counties on PSRO and is concerned about the lack of a mechanism whereby information on these activities can be shared.

Your Reference Committee therefore suggests that the Florida Medical Association seriously consider the establishment of a clearing house for information on PSRO activities in Florida.

The Reference Committee moved that Board of Governors Recommendation No. 4 be adopted. A substitute motion was made from the floor to delete the third Resolved of Recommendation No. 4. The substitute motion carried. A motion was made from the floor to add the words "to participate or" after the word "option" in the second Resolved of Recommendation No. 4. The motion carried. Recommendation No. 4 was adopted as changed. (See Report of Board of Governors, Page 442).

The Reference Committee moved that the Board of Governors seriously consider establishing a clearing house for information on PSRO. A motion from the floor to add another paragraph to this recommendation carried, and the House adopted the motion as follows:

That the Board of Governors seriously consider establishing a clearing house for information on PSRO, and further requests the Board of Governors to evaluate existing and applicant PSRO CMA units in regard to whether the intent of FMA policy as to approval by 50% of its membership has been, and is being, respected.

Resolution 76-27

Relative Value Studies

Recommendation No. 5

This Resolution had been referred to the Board of Governors. It recommended that further studies or references to Florida Medical Association Relative Value Studies, except where required by law, be terminated. Current efforts of the Federal Trade Commission and Justice Department on relative value studies and pending legislation have been considered previously under Item 3 of this report. No testimony was offered on Recommendation No. 5. The Board of Governors recommends that Resolution 76-27 be disapproved.

The motion of the Reference Committee that Recommendation No. 5 of the Board of Governors be adopted, and that Resolution 76-27 be disapproved carried. (See Report of Board of Governors, Page 443).

Board of Governors Report, Councils and Committees, Council on Medical Economics

DHRS Maximum Medical Compensation Schedule

The motion of the Reference Committee that the Board of Governors Report on DHRS Maximum Medical Compensation Schedule be filed carried. (See Report of Board of Governors, Page 447).

Workmen's Compensation

The motion of the Reference Committee that the Board of Governors report on Workmen's Compensation be filed carried. (See Report of Board of Governors, Page 447).

Committee on Cost of Medical Care

The motion of the Reference Committee that the portion of the Board of Governors Report on the Cost of Medical Care be adopted carried. (See Report of Board of Governors, Page 447).

Council on Medical Systems Confidentiality of Health Care Information

The motion of the Reference Committee that the portion of the Board of Governors report on Confidentiality of Health Care Information be adopted carried. (See Report of Board of Governors, Page 448).

Data Broker Concept

The motion of the Reference Committee that the portion of the Board of Governors Report on Data Broker Concept be filed carried. (See Report of Board of Governors, Page 448).

Medicaid Management Information System

The motion of the Reference Committee that the portion of the Board of Governors Report on Medicaid Management Information System be filed carried. (See Report of Board of Governors, Page 448).

Florida Health Data Corporation

The motion of the Reference Committee that the portion of the Board of Governors report on the Florida Health Data Corporation be adopted carried. (See Report of Board of Governors, Page 448).

PMUR—Champus Program

The motion of the Reference Committee that the word "unanimously" in the first line of Recommendation No. 10 be deleted carried.

The motion of the Reference Committee that Recommendation No. 10 be adopted as changed carried. (See Report of Board of Governors, Page 448).

Peer Review

The motion of the Reference Committee that the portion of the Board of Governors Report on Peer Review be adopted carried. (See Report of Board of Governors, Page 448).

PMUR Case Review

The motion of the Reference Committee that the portion of the Board of Governors report on PMUR Case Review be adopted carried. (See Report of Board of Governors, Page 448).

Committee on Nursing Homes

"Your Reference Committee heard substantial testimony on this portion of the Board of Governors report. It indicated that there may be discrepancies between the recommendations of the Committee on Nursing Homes and Medicaid statutes and regulations. Your Reference Committee agrees with the recommendations of the Committee on Nursing Homes that have been adopted by the Board of Governors. There is a clear need for the Department of HRS to more clearly define the three levels of care in nursing homes. There is also a great need for a nursing home review policy and procedures manual.

"Further testimony indicated concern for over-utilization of services by physicians, especially those who provide 'gang visits' to nursing home patients. Your Reference Committee shares this concern and strongly supports the Board of Governors action in encouraging Florida Medical Association members to see their nursing home patients when medically necessary."

The motion of the Reference Committee that the portion of the Board of Governors report on Committee on Nursing Homes be adopted carried. (See Report of Board of Governors, Page 451).

Blue Shield

The motion of the Reference Committee that this portion of the Board of Governors report be filed carried. (See Report of Board of Governors, Page 451).

Special Committee on Nursing Homes

The Reference Committee was impressed with the complexity of the problems relative to the care provided to patients in nursing homes and commended the Committee for its efforts to resolve these problems.

The motion of the Reference Committee that the report of the Special Committee on Nursing Homes be adopted carried. (See Report of Board of Governors, Page 451).

Subcommittee on Medicaid

The Reference Committee noted that after three years of discussion, a contract for PMUR for Medicaid has been submitted to the Department of HRS. The signing of this contract has been delayed pending the funding level for Medicaid by the Florida Legislature, but finalization of the contract is expected by July 1, 1977. The Reference Committee encouraged this subcommittee to continue its efforts to improve the Medicaid Program.

The motion of the Reference Committee that the report of the Subcommittee on Medicaid be adopted carried. (See Report of Board of Governors, Page 467).

Committee on Cost of Medical Care

The Reference Committee reported that the Committee on the Cost of Medical Care, chaired by James F. Richards Jr., M.D., is a multi-organizational committee, and that the Committee was impressed with the imaginative recommendations that are being developed. It strongly urged continuation of its efforts.

The motion of the Reference Committee that the Report on the Cost of Medical Care be adopted carried. (See Report of Board of Governors, Page 447).

Resolution 77-2

Current Procedural Terminology Broward County Medical Association

The Reference Committee reported that this resolution was withdrawn by a representative of the Broward County Medical Association.

Resolution 77-3

RVS Modifier-48

Escambia County Medical Society

Resolution 77-3 was not considered as no sponsor appeared before the Reference Committee.

Resolution 77-5

Health Systems Agency Capital County Medical Society

"This Resolution would request the Florida Med-

ical Association to assist in any way a test of the constitutionality of PL 93-641. This Reference Committee report concerning the Council on Medical Systems, describes the legal efforts that are currently in progress with respect to PL 93-641. Dr. Francis T. Holland, Vice President of the AMA, has described efforts of the AMA to support a legal test of the law. Since the 'resolved' portion of Resolution 77-5 implies the possible expenditure of substantial sums of money, and since there is some indication that an additional legal test might result in further delay in a court decision, your Reference Committee believes that this Resolution should be referred to the Board of Governors for its review and appropriate action. Your Reference Committee has great concern, however, of the adverse effects of this law."

The Reference Committee moved that Resolution 77-5 be referred to the Board of Governors for consideration.

Resolution 77-5

Health Systems Agency

[NOT ADOPTED — REFERRED TO THE BOARD OF GOVERNORS]

Whereas, The Health Systems Agency, created by Public Law 93-641, has established non-profit corporations operating with federal, state and local funds for the purposes of health planning, and

Whereas, The Health Systems Agency through certificates of need and other regulatory procedures has the effect of law in controlling all phases of the practice of medicine including construction, equipment purchases and decisions on the actual treatment of patients through criteria for renal dialysis, coronary care, etc., and

Whereas, The Health Systems Agency is a self-appointed self-perpetuating organization whose members are not elected by the public and the public has no method of removing or impeaching the members, clearly representing a violation of the constitution concerning representative government, and

Whereas, The activities of the Health Systems Agency, designed to help contain the increasing costs of medical care, have produced the opposite effect by increasing the competition for certificates of need for construction and equipment and the creation of artificial barriers to the free enterprise system by the creation of monopolies, therefore, be it

RESOLVED, That the Florida Medical Association assist in any way possible to test the constitutionality of the Health Systems Agency and Public Law 93-641.

Resolution 77-9

Blue Shield of Florida

Sarasota County Medical Society

"This Resolution provides for the continued support of the Board of Directors of Blue Shield and suggests that there be a general review of the qualifications and efficiency of the executive staff of Blue Cross/Blue Shield. Extensive testimony indicated such management and operational reviews of Blue

Shield continue on a regular basis as part of Blue Shield operating procedure. Your Reference Committee was further informed that a joint committee of the Blue Cross/Blue Shield Board of Directors has been established and charged with the responsibility of initiating such reviews of Blue Cross/Blue Shield operations as seem appropriate." Your Reference Committee is in accord with this approach and believes that continuation of the use of outside management consultant firms should be continued when appropriate."

The Reference Committee offered a substitute for Resolution 77-9. The motion of the Reference Committee to adopt the substitute for Resolution 77-9 carried.

**Substitute Resolution 77-9
Blue Shield of Florida**

RESOLVED, That the House of Delegates of the Florida Medical Association continue its support of the Board of Directors and administrative staff of Blue Shield and urge the continuation of review of Blue Shield administration and operations including the use of external consultants.

**Resolution 77-16
BC/BS — Waiver of Coverage
Alachua County Medical Society**

"Resolution 77-16 brings to the attention of the House of Delegates some problems relative to waivers of coverage which are being applied to Blue Cross and Blue Shield contracts. The Committee heard testimony that a broadly based Blue Cross/Blue Shield internal task force has been established to review all contracts, giving particular attention to waivers and riders. Your Reference Committee applauds this effort. We were informed, however, that changes in some Blue Cross and Blue Shield contracts require the approval of the Insurance Commissioner. Your Reference Committee, therefore, believes that this Resolution should be referred to the Board of Governors so that it can monitor the results of this task force's efforts."

The Reference Committee recommended that Resolution 77-16 be referred to the Board of Governors with a request for a progress report to be submitted to the House of Delegates at the 1978 Annual Meeting.

**Resolution 77-16
BC/BS — Waiver of Coverage
Alachua County Medical Society**

[NOT ADOPTED — REFERRED TO THE BOARD OF GOVERNORS]

Whereas, Florida Blue Shield and Blue Cross, sponsored by doctors and hospitals, were organized as non-

profit organizations for the purpose of offering a method for prepaying unforeseen hospital and medical expenses, and

Whereas, Waiver of Coverage as required by Florida Blue Shield and Blue Cross in certain specific instances (i.e., a duodenal ulcer patient being required to waive coverage for the entire GI tract; a patient with fibroids of the uterus being required to waive coverage of the entire genital tract, etc.) are grossly unfair and not in keeping with the stated purposes of Florida Blue Shield and Blue Cross, be it

RESOLVED, That the Florida Blue Shield and Blue Cross cease the present administrative practice of requiring total waiver and institute a practice of requiring waiver of only those problems related directly to the condition in question and not the total system; be it further

RESOLVED, That Florida Blue Shield and Blue Cross revise the waiver provisions of current individual contracts to provide that the waiver of coverage applies only to pre-existing problems and those problems related directly to the condition in question and not the total system; be it further

RESOLVED, That the officers, Board of Governors, committees, members and employees of the Florida Medical Association be directed to use their offices to implement this Resolution through Florida Blue Shield and Blue Cross.

**Resolution 77-12
Florida Physicians' Insurance Reciprocal
Duval County Medical Society**

Resolution 77-12 was not considered as no sponsor appeared before the Reference Committee.

**Resolution 77-13
Advisory Committee to Florida Physicians'
Insurance Reciprocal
Duval County Medical Society**

Resolution 77-13 was not considered as no sponsor appeared before the Reference Committee.

**Resolution 77-25
Medicare-Blue Shield
FMA Executive Committee**

"Your Reference Committee was informed that Resolution 77-25 was adopted by the Florida Medical Association Executive Committee in respect to Part B Intermediary Letter No. 77-11, entitled, Effect of 'Government in the Sunshine Act' on Disclosure of Information. This intermediary letter authorizes Medicare fiscal intermediaries to disclose information about customary charges of physicians as well as information about the way in which Medicare reimbursement was determined in specific claims.

"Your Reference Committee agrees with the Executive Committee in opposing the release of such information and was pleased to learn that the Blue Shield Board of Directors has unanimously adopted a policy of refusing to release the names of physicians and their profiles and fees. Your Reference Committee therefore supports the first Resolved in Resolution 77-25.

"Extensive discussion before the Reference Committee indicated a significant difference of opinion as to the desirability of having the Florida Medical Association take a position at this time on a request for Blue Shield to terminate its contract as fiscal intermediary to Medicare Part "B" if Blue Shield had been mandated to release such information. Further, your Reference Committee is concerned about the impact of such anticipatory action by the Florida Medical Association on the pending contract between Blue Shield of Florida and the Bureau of Health Insurance for Blue Shield to continue for another year as Part "B" intermediary. This contract is in the final stages of negotiations.

"Your Reference Committee therefore believes that the second Resolved in Resolution 77-25 should be referred back to the Board of Governors for prompt action if and when such action is indicated."

The motion of the Reference Committee that the last "Resolved" of Resolution 77-25 be separated from the Resolution and referred to the Board of Governors for recommendations to the House of Delegates at such time as Blue Shield is mandated to release information on physician customary charges and other information as outlined in intermediary letter 77-11 carried.

Medicare — Blue Shield

[NOT ADOPTED — REFERRED TO THE BOARD OF GOVERNORS]

RESOLVED, That if Blue Shield is forced by the Federal Government to release this information, the FMA requests Blue Shield to terminate its contract as fiscal intermediary for Medicare, Part "B", at the earliest possible date.

The Reference Committee moved a change in the remaining Resolved of Resolution 77-25. The motion carried. The motion of the Reference Committee that Resolution 77-25 be adopted as amended carried.

Resolution 77-25 Medicare-Blue Shield

RESOLVED, That Blue Shield of Florida, a fiscal intermediary for Medicare, Part "B", refuse to release the names of physicians and their profiles or fees.

The Reference Committee expressed its sincere appreciation to all the members who came to speak before the Committee. The Chairman stated that their contributions to the deliberations of the Reference Committee were enlightening and of great assistance to the Committee. The Chairman also thanked the members of the Committee, Drs. Warren Lindau, Charles McConnell, John Parker, and Andre

Capi, and the Committee's Delegate Advisor, Dr. Jim Cook, for their diligent efforts in the work of the Committee and preparation of the Committee's report. The Committee expressed special thanks to Marcia Protheroe, its recording secretary, for her perseverance and untiring efforts in the preparation of the Committee's report, and John Richardson, of the FMA staff, for his assistance and counsel to the committee.

The motion of the Reference Committee that the report of Reference Committee V be adopted as a whole as amended carried.

A request was made from the floor by Janice Sherwood, M.D., Dade County Medical Association delegation, to introduce a non-controversial resolution. The request was granted.

"ON BEHALF OF THE DADE DELEGATION AND WITH THE UNANIMOUS CONSENT OF THIS HOUSE OF DELEGATES, I WOULD LIKE TO MOVE THAT WE SUPPORT VIGOROUSLY THE AMA'S STAND CONDEMNING PRESIDENT CARTER'S PROPOSAL TO IMPOSE AN ARBITRARY CEILING ON HOSPITAL CHARGES." The motion carried.

The Speaker recognized Dr. Donald G. Nikolaus of Pinellas County.

"Mr. Speaker, my entire Delegation has asked me to rise for a point of information. I request being heard as a point of personal privilege as a member of the Board of Governors.

"In the rules of order of this esteemed body of physicians, it would be out of order for this Delegation to offer a motion to the floor which has not gone to Reference Committee. However, our Delegation feels it is equally out of order for the physicians here present not to recognize the fact that today is Mothers Day!

"Many of us are accompanied to this convention by our wives who, as is their custom, continue to support us in our professional obligations. Because they are with us here, they cannot be at home to be honored by their children.

"If it were possible, this Delegation would offer a resolution which would read as follows:

"WHEREAS, The wives of physicians are frequently called upon to give an extra measure of motherhood because her partner is absent due to professional pressures,

"WHEREAS, These lovely ladies share with us the social pressures, political harrassment, and frustrations of life, and

"WHEREAS, These are without doubt the most magnificent of all of God's creations, we would

"RESOLVE, That we, as a body, should recognize that we are fortunate in being so blessed, and further

"RESOLVE, That we should recognize this day as a time of special significance to us as physicians."

But since we cannot make such a motion without prior House action, we leave it to the Speaker to take appropriate action."

The Speaker declared the motion in order, and the resolution was adopted by unanimous consent of the House.

Elections

President-Elect

The Speaker opened the floor for nominations for the office of President-Elect of the Association for 1976-77.

Dr. Ed Annis placed in nomination the name of Dr. O. William Davenport of Miami, Florida.

Dr. Davenport's nomination was seconded by Dr. James Borland of Duval County. Dr. Anthony J. Vento of Broward County also seconded the nomination of Dr. Davenport and moved that the nominations be closed and that Dr. Davenport be elected by acclamation. Nominations were closed and Dr. O. William Davenport was elected President-Elect by acclamation.

Vice President

The floor was opened for nominations for the office of Vice President.

Dr. Thomas Caswall of Polk County placed in nomination the name of Dr. John W. Glotfelty of Lakeland, Florida.

Dr. Glotfelty's nomination was seconded by Dr. Jere Annis of Polk County; Dr. Ray E. Murphy, Jr. of Broward County; Dr. Victor H. Knight, Jr. of Hillsborough County; Dr. G. Brock Magruder of Orange County; and Dr. Franklin J. Evans of Dade County.

Dr. Thomas D. Bartley of Alachua County placed in nomination the name of J. Lee Dockery of Gainesville, Florida.

Dr. Dockery's nomination was seconded by Dr. Charles F. Tate, Jr., of Dade County; Dr. Thomas E. McKell of Hillsborough County; Dr. Theodore J. Marshall of Escambia County; Dr. Calvin W. Martin of Desoto-Hardee-Glades County; Dr. James B. Perry of Broward County; Dr. T. Byron Thames of Orange County; and Dr. Yank Coble of Duval County.

Nominations were closed and upon secret written ballot Dr. Dockery was elected.

Dr. Glotfelty moved that a unanimous vote be recorded for Dr. Dockery. The motion carried.

Speaker of the House

The floor was opened for nominations for the office of Speaker of the House.

Dr. Donald G. Nikolaus of Pinellas County moved that all of the names of the incumbents for the positions of Speaker of the House, Vice Speaker, Secretary, Treasurer, Delegate and Alternate, Seat No. 1, Delegate and Alternate, Seat No. 4, Delegate and Alternate, Seat No. 6; Delegate and Alternate Seat No. 7 be placed in nomination and that nominations be closed. The motion carried. All incumbents to these stated offices were elected by unanimous vote of the House.

Judicial Council

The Speaker referred the House to the report of the Board of Governors, in which the Board nominated Dr. Joseph H. Davis, Miami, to the House of Delegates for election to the Judicial Council at-large for a five year term.

The nomination of Dr. Joseph H. Davis, Miami, to the Judicial Council at-large for a five year term was adopted, and Dr. Davis was elected.

Committee on Membership and Discipline

The Speaker referred the House to the nominations for election to the Committee on Membership and Discipline as submitted by the Board of Governors in its report, and asked for additional nominations from the floor. It was noted that in District 9, Dr. Lee Rogers had retired and was no longer available to serve on the Committee on Membership and Discipline. The name of Dr. Burton Podnos was substituted for Dr. Lee Rogers in District 9. There were no additional nominations from the floor. Motion carried to elect the nominees submitted by the Board of Governors to the Committee on Membership and Discipline with the one noted substitution. (See Report of Board of Governors, Page 441).

The Speaker introduced Dr. Murray, the new President.

Dr. Murray then introduced the new Board of Governors.

Dr. Murray announced that the members of the Board of Governors would meet immediately following adjournment of the House.

The Speaker resumed the Chair and called on Dr. Henry J. Babers, Past President, for the Benediction.

Dr. Babers: "Dear Lord, please hear our prayers, forgive us our sins. Please protect us and guide us as we return to our daily lives."

The 1977 House of Delegates adjourned at 12:30 p.m.

Lost Children

J. M. Whitworth, M.D.

"Society will succeed or fail in direct proportion to the way it enhances or impedes the development of its children."

Noshpitz

Child abuse and neglect are responsible for at least two reported deaths per day in this country. Untold numbers of children are injured physically or mentally by their parents, as the number of cases reported only represents the tip of a huge submerged iceberg.

Child abuse is undergoing an evolution similar to the changes seen in our view of alcoholism in that there is now emerging an understanding of child abuse as a medical problem rather than a problem of law enforcement. There is an accompanying new wave of interest in broadening our knowledge and resources to attack the problem, as we have other medical threats to children in the past.

Child advocacy to prevent and identify abuse and neglect has not always been a concern of society, since abuse must be defined based on insight into the child's place in the family and an understanding of the adult view of the child at any given time in history. For example, in antiquity, infanticide was a common practice as a means of effective population control, and at the time was probably the only way population could be effectively matched with available food and natural resources. Based on modern models, this practice could only be viewed as child abuse, but at the time it was the only available solution to a problem which threatened an entire society. Times change, and with them, definitions.

A similar evolution has taken place in the United States but it has been tied more closely to a combination of religious, psychological and legal factors, rather than economic pressures. In the

Seventeenth Century, for example, the Puritans viewed their children as miniature adults who were born depraved. It was the responsibility of the parent to see to it that this depravity was rapidly corrected. The approach was a combination of frequent and severe physical punishment with explanation of the punishment on an adult level - a reasonable example of modern day physical and emotional abuse.

In 1842, Horace Bushnell enunciated the theory that children were not really depraved and that they seemed to pass through stages of development rather than being born as miniature adults. This amazing observation led to an interest in observing children and may have been, in part, responsible for the beginnings of child advocacy in this country. It was 50 years later, however, before the first legal battle in child abuse was fought. It was the case of Maryjane who was beaten and neglected by her parents in New York. Authorities could find no legal precedent for action against her parents, as children had always been considered chattel, and no laws protecting them from physical harm existed. Prosecution was undertaken, however, under the laws for the prevention of cruelty to animals by the Society for the Prevention of Cruelty to Animals and the child was successfully removed from her abusive parents.

Evolution of child psychology theory and practice continued through the Twentieth Century with various theories finding advocates and practitioners depending on the many factors which mold society as a whole. The child abuse problem, however, remained relatively well submerged except to a concerned few.

A new era began in 1946 when Caffey described radiographic findings in children which included subdural hematomas and multiple fractures with no

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reasonable explanation. This was followed in 1955 by Wooley and Evans correlating these findings with suspected parental abuse. The term "Battered Child Syndrome" was coined by Kempe in 1961. The surge of current interest, research, and action really began at that point.

Chapter 827 Florida Statutes was passed by the Florida legislature in 1973, defining abuse and also instituting a mandatory reporting system. The law defines Child Abuse and Neglect as "Abuse or maltreatment includes any willful or negligent acts which result in neglect, malnutrition, sexual abuse, unreasonable physical injury, material endangerment of mental health, and failure to provide sustenance, clothing, shelter or medical attention." Mandatory reporting resulted in a thousand-fold increase in the number of reports received by the Department of Health and Rehabilitative Services in one year. The logistics of managing these reports became an immediate problem and as statistics began to accumulate it became apparent that, interestingly, a very small number of these reports were coming from health professionals. The reasons for failure of reporting by physicians, in spite of a prescribed penalty for such failure, have been elucidated by others. The first and most obvious problem is inadequate undergraduate and postgraduate training of physicians. Public and professional education in child abuse is underway in many areas of Florida to help rectify this problem; the references following this article provide a concise short course in child abuse.

The second group of problems surround the relationship between physicians and various agencies and systems in the community, including poor experiences with community service agencies, fear of the law or going to court, and inability to relate to other professionals in a peer relationship. The solution to these problems is to do one of two things: Become involved with the systems and people to overcome lack of understanding of their problems and to concomitantly allow them to understand yours. Personal contact will begin to dissolve some of your insecurities and automatically improve communications. In addition, begin to act as an agent for change in your community. If there are inadequacies in the system, begin to act as an advocate to change those systems or develop new systems for handling children's problems.

Other real and continuing barriers to physician reporting include fear of dealing with irate parents, uncertainty regarding the situation, lack of support

by internal administrative systems and seeing the child in need of punishment received. A few comments on these barriers are in order.

The fear of dealing with irate parents is often an unfounded one. Many abusive parents come to you with an unstated but strong desire for help. Ninety five per cent of abusive parents are not mentally ill and would welcome understanding intervention. For those who may be irate, a simple explanation of your duty by law and further reinforcement that there are no accusations involved on your part will usually suffice.

If you are uncertain — report!! Florida State law requires reporting of any **suspected** abuse and does not require proof. Your goal must be to protect the child and this goal can best be served by reporting all suspect cases. Internal administrative systems do not change your responsibility as a physician and your responsibility to the child. Administrative systems can be changed but moral responsibilities cannot.

There are still a few Puritans among us and I can only comment that no child is in need of abuse and one should consider altering his own internal systems defining child rearing practices if he sees otherwise.

More subtle problems in interpretation of the new law became apparent. In practical terms, it is sometimes difficult to translate legal definitions into operational definitions. For example, emotional neglect and maternal deprivation ("material endangerment of mental health") are very difficult to define operationally except when they result in failure to thrive. Since failure to thrive has been estimated to be the result of maternal deprivation in at least 70% of cases, it becomes extremely important to determine those parameters of parent-child interaction responsible for optimal intellectual and physical development. The research of Klaus, Brazelton and others into mechanisms of bonding and parent-child interaction have helped considerably in this direction. Physical neglect and battering are more easily definable and identification is usually not difficult.

How do we recognize child abuse in the primary care setting? There are certain physical findings which must be considered red flags and diagnostic of abuse until proven otherwise. These include bruises in any child under one year, fractures in any child under two, dislocations of hips or spine, subdural hematomas, and circumferential burns under the age of three.

Other typical findings of abuse include multiple

rib fractures, buckle deformities, metaphyseal chip fractures and skull fractures. Bruises clustered on the trunk and buttocks are common.

Any of these findings, accompanied by a history inadequate to explain such findings, should arouse your suspicion that the child has been abused. Other suggestions of abuse include parent/child role reversal, history of high risk pregnancy and/or prematurity, "special child" (physical disability, retardation, hyperkinesis), disorganized or unsupporting spouse relationship, frequent emergency department visits and being a member of a multi-problem family.

Although theories to explain the dynamics of child abuse vary somewhat, there is a common thread with which there is no disagreement. Child abuse is usually the result of a defect in parenting skills or parental modeling on the part of the abuser. Manifestations of defective parenting are best described by Helfer and referred to as the "world of abnormal rearing." In summary, the abusive parent model provides negative feedback on a continuous basis either by overt or covert abuse. The child begins to identify contact with the parent model as a negative experience and then generalizes the feeling to outsiders as well. She becomes isolated by choice, or by necessity. In addition, she begins to feel that there must be something defective about her if she deserves all this negative input, and thus gradually develops a defective self-image, further forcing her into isolation from others. She has no opportunity to develop interpersonal skills leading to an eventual inability to select a spouse supportive to her needs. With isolation, a defective self image, and no supporting spouse, the individual feels some of her needs might be fulfilled by having a baby. Not only does the mother have expectations for the baby to fulfill but also has learned methods to accomplish the desired behavior from her own mother. Frustrated by lack of appropriate response and isolated so that she cannot escape her frustrations, she eventually reacts by reproducing the same patterns she has been taught - abuse.

Other factors are, of course, important. These include alcoholism, drug abuse, economic pressures and a myriad of other disruptive problems. These factors can generally, however, be thought of as aggravating influences superimposed on the basic pathologic parenting picture. Most people do not realize that parenting is a learned skill rather than an instinct. Society has made attempts to teach mother-craft but, until recently, few attempts have been made to teach parenting, believing instead, we could depend on instinct or

appropriate modeling in parenting for the individual. The development of "Parent Effectiveness Training" and similar programs have addressed this need. These attempts should be applauded, but it should be kept in mind that most programs such as these require a significant amount of motivation on the part of the parent and, therefore, only reach a small proportion of those who really need the training. If we really are concerned, really believe that parenting is an important skill to help prevent child abuse and neglect, and really want to be advocates for future generations, why are we not implementing the simplest solution — parenting training in our secondary schools? Craft classes in baby care are not enough. Parenting classes to reach our next generation of parents prospectively are needed.

Treatment modalities for abuses have varied with time and place. In some areas "treatment" is principally the incarceration of the abuser for varying periods of time, depending on the severity of the abuse. As an awareness develops that child abuse is usually more akin to a disease than a crime, incarceration is giving way to various psychiatric methods which have met with differing degrees of success. Since most abusers do not have an identifiably psychosis, the more classical forms of individual psychotherapy have limited effectiveness. Other forms of therapy have, however, shown great promise with abusers. For example, group therapy has been shown to be an effective and productive means for abusive parents to begin to deal with their problems and also to begin to break the isolation spiral. More recently, family therapy has been shown to be successful.

Current theory and practice can be divided into two approaches: those which remove the child to another environment and work with parents, and those which attempt to leave the family intact and work with the entire family unit. Although the latter certainly offers philosophical advantages, it also requires tremendous manpower to assure the protection of the child and is probably not realistic except under very special circumstances. The success rate of therapy under proper conditions in both groups is very high.

When looking at children's legal and medical programs, however, one cannot escape the need to comment on persistence of tremendous concern with the rights of parents and marginal or minimal concerns with the rights of children. It would seem the burden of proof of abuse is on the child. The parents remain innocent until proven guilty which is certainly an acceptable legal principle, but who

represents the interests of the child? Who is removed from the house—the abuser or the abused? Who is most likely to be referred for long term therapy? Finally, who is least able to defend himself in the legal system? If answers to these questions are all in favor of the abuser, we must question the status of child advocacy.

Agencies dealing with children need to be more child-oriented. This statement does not refer to the provision of playrooms in agency facilities, but rather, an orientation to the development of an approach which recognizes that children have rights separate and apart from the rights of their parents. When abused or neglected they have equal rights of representation and legal recourse with their parents. In short, children's rights should be positive rights rather than negative or "left-over" rights.

In summary, we have observed the child abuse and neglect problem in terms of numbers, we have looked at some of the indicators for and mechanisms of child abuse and neglect, and have

made a plea for intervention from an educational and advocacy standpoint. What else can be said?

David Walters, in his book, "Physical and Sexual Abuse of Children, Causes and Treatment" made a statement which may suffice. He said, "It is unfortunate we did not receive an Eleventh Commandment, Honor Thy Children."

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- Dr. Whitworth, Department of Pediatrics, University Hospital of Jacksonville, 655 West Eighth Street, Jacksonville 32209.

Cracker Cures

Sprains

For sprains, lame back, rheumatism and caked breasts, take four good sized toads. Put into boiling water and cook until soft. Remove the toads and boil the water down until about a half pint and add fresh, unsalted butter (1 pound) and simmer, then add two ounces of arnica.

Reprinted by permission from "Cracker Cures," a publication by the Peece River Valley Historical Society. Edited by Cedric Stephen Wood, P.E. These cures have been collected over the years by friends and members of the Peece River Valley Historical Society and presented a few at a time at each of their regular meetings by Dr. Gordon H. McSwein, custodian.

Primary Non-Hodgkins Lymphoma of the Breast Case Report

C. H. Amar Inalsingh, M.D.

Abstract: A 44-year-old female is presented with a diagnosis of primary non-Hodgkins lymphoma of the breast. The problems associated with the histopathologic diagnosis and subsequent management of the patient are discussed, also the role of surgery, radiotherapy and chemotherapy.

Primary non-Hodgkins lymphoma of the breast is a relatively rare disease.¹ It is seldom considered in the differential diagnosis of clinically malignant breast lumps since adenocarcinoma of the breast is common.² There was, therefore, some surprise when a surgeon received a frozen section report of positive malignancy, uncertain in type, in a patient with clinically suspicious breast cancer.

A final diagnosis of moderately well to poorly differentiated lymphocytic lymphoma dictated a change in management plans.

Case Report

The 44-year-old female had been in excellent health until the beginning of December 1975 when she noticed a swelling of her left nipple. She saw her physician on 1/15/76. At that time the nipple was enlarged, inflamed and tender with some subareolar induration. There was no discharge. Her physician believed this was ductal mastitis and she was given antibiotics. With a decrease in swelling and tenderness resulting from therapy, a breast mass could be palpated in the subareolar tissue. On 1/20/76 she had bilateral xeromammography, which was negative. Because the mass remained clinically suspicious of malignancy, she was admitted to Manatee Memorial Hospital on 2/4/76 for biopsy and possible mastectomy. During hospitalization the workup including EKG, chest x-ray, CBC, urinalysis, serum chemistries, and liver function tests did not reveal any abnormalities. The past medical history was noncontributory.

On 2/5/76 she had an excisional biopsy of the mass. The frozen section report stated that the lesion appeared to be an inflammatory reaction; there were areas suspicious but not

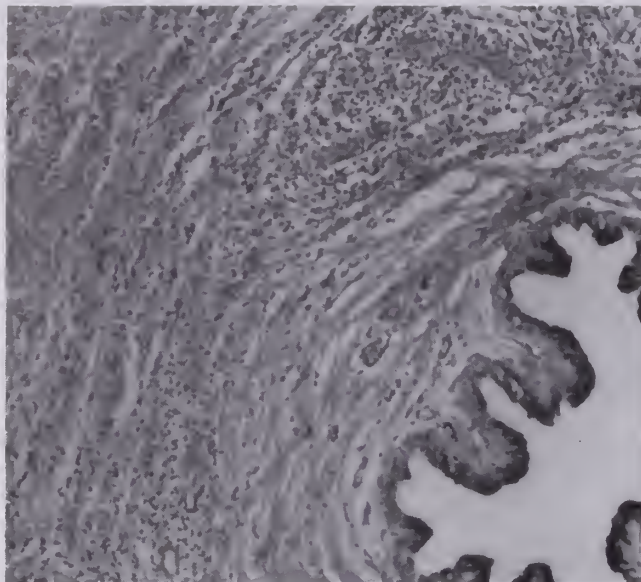
conclusive of malignancy. The mastectomy was not done. Examination of permanent sections (Figs. 1, 2), revealed that portions of breast tissue were diffusely infiltrated by a pleomorphic lymphoid cell infiltrate which appeared to destroy the present connective tissue septa and fibromuscular walls of the ducts present. The ductal epithelium, however, was preserved and showed no significant histologic abnormalities. The cellular infiltrate consisted of atypical histiocytes admixed with lymphoblasts and mature lymphocytes. Plasma cells were present but not numerous. Eosinophils were conspicuously absent. In some zones there appeared to be formation of reticulum. The provisional diagnosis was subareolar pleomorphic malignant lymphoma of the breast. The Armed Forces Institute of Pathology reviewed the slides and reported that periductal arrangement of the malignant infiltrate indicated a moderately well to poorly differentiated lymphocytic lymphoma. However, a small cell undifferentiated carcinoma could not be absolutely excluded.

Further workup including a bone marrow biopsy, liver-spleen scan, gallium scan and lymphangiography provided essentially negative results.

On 3/16/76, the left breast scar had healed satisfactorily but there was a ½ cm mobile node in the left axillary tail area. This node was believed to be clinically positive and was not biopsied. The left axilla, itself, was negative. There were no other significant clinical findings. She was staged IIE non-Hodgkins lymphoma because the tumor involved two areas above the diaphragm, the breast and the axillary tail node. After discussion of management with her physicians, it was agreed that she should be treated by radiation therapy. A mastectomy was believed not indicated and chemotherapy could be reserved for a later date. Treatment was started by using a 4 MeV linear accelerator on 3/18/76 and completed on 4/15/76. She had a dose of 4000 rads in 20 fractions to the left breast and lymphatic drainage areas above the diaphragm using a mantle field technique and tangential fields for the breast. She tolerated treatment well and had minimal reaction to it. She has been followed as an outpatient and when last seen on 3/2/77 was in good health without any evidence of recurrence.

Discussion

This case illustrates some of the problems in managing a relatively rare disease in a county



Figs. 1 and 2. — Photomicrographs of tissue from the breast biopsy.

hospital. Primary sarcoma of the breast constitutes about 1% of all malignant lesions of the breast and primary lymphoma is only part of this small percentage.² This patient is in the age group in which carcinoma of the breast is common. Clinically the diagnosis was uncertain even from the very beginning when her primary physician felt the changes could have been inflammatory. The negative xeromammography added further uncertainty. In retrospect, this was the first indication that this patient did not have adenocarcinoma of the breast since lymphomas of the breast do not appear to have a distinctive radiological pattern.³ However, based on the clinical suspicion of malignancy, a biopsy of the breast was carried out prior to possible mastectomy. With an equivocal frozen section report, it was wise of the surgeon to await the permanent sections. When these became available, there was still some uncertainty as to whether the diagnosis was that of undifferentiated carcinoma or lymphoma. After a second opinion, a final diagnosis of moderately well to poorly differentiated lymphocytic lymphoma was made. Because the biopsy tissue was extralymphatic, Rapport's distinction between nodular or diffuse pattern could not be made. It now became necessary for the patient to have a lymphoma workup. This was carried out but was negative. Staging was done according to the Ann Arbor system of IIE because of the extralymphatic primary lesion and involvement of one regional

lymph node. Staging laparotomy was considered but was not carried out. It was believed that the nodes below the diaphragm were negative and would be followed up by abdominal x-rays while dye remained from the lymphangiogram.

Having made the diagnosis and staged the patient, treatment was then considered.

Extended simple mastectomy, recommended in this disease,^{1,4} was rejected because it was felt to be too mutilating a procedure in this relatively young woman who preferred not to have a mastectomy.

The role of radiation therapy was then considered. Whole body radiation as advocated by Johnson⁵ was not believed to be the appropriate treatment since this patient had primarily breast disease. Extended field radiation therapy as advocated by Levitt⁶ was thought to be more suitable in view of the clinically positive axillary node and negative workup. It was agreed that radiation therapy to the breast and lymph nodes above the diaphragm would be the appropriate way to treat this patient. The decision to treat these nodes was based on the work of several authors⁶⁻⁸ who advocate prophylactic radiation in the diffuse poorly differentiated lymphocytic or diffuse mixed lymphomas.

The use of postradiation chemotherapy was then considered. Chemotherapeutic agents have been advocated in poorly differentiated lymphocytic lymphoma in the early stages^{9,10} but in

view of a primary breast site and one involved lymphatic gland area, it was reserved for possible use at a later date.

Acknowledgements

I would like to thank Albert Simkus, M.D., and Patrick Sullivan, M.D., for their cooperation in the care of this patient. I would also like to thank David Fulghum, M.D., for reviewing the manuscript and Karen McGinn for assisting in its preparation.

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Fee for Service in Early America

When he was rector of the University of Virginia, Thomas Jefferson brought 26-year-old Robley Dunglison from England to be UV's first professor of medicine. In his waning years, Mr. Jefferson was attended by Dr. Dunglison, who refused to send a bill for his services.

Mr. Jefferson's reply (as printed in the April 1977 issue of *The Pharos of Alpha Omega Alpha*:

Monticello, November 26, 1825

Dear Doctor

Your letter of the 18th (which contained Dunglison's refusal of compensation) places me under great embarrassment. The fragment of life remaining to me is likely to be passed in sickness and suffering. The young physicians in our neighborhood will probably be good ones in time. But time & experience as well as science are necessary to make a skilful physician, and Nature is preferable to an unskilful one. I had therefore made up my mind to trust to her altogether, until your arrival gave me better prospects. But these again seem likely to be disappointed by a refusal on your part to receive a just compensation for your services, without which it is impossible for me to consent to the trouble of your rendering them. I thought we had settled it

otherwise; and I still hope you will relieve me by receding from this scruple and permitting me to avail myself of your skill and cares, on the footing of others; in which confidence, I enclose you an order on Mr. Raphael (who holds my little bank here) for a sum which I have been obliged to name by guess, being entirely ignorant of what it should be. I am sure it is not too much, and if too little say so with freedom and it shall be immediately corrected. Grant me this favor, dear Doctor as an assurance that I may freely expect your aid on the only condition on which I can possible reconcile to myself to ask it.

ever and affectionately yours
Th: Jefferson.

For the young who take umbrage at Mr. Jefferson's emphasis on the need of time to insure the appropriate ripening of a physician, remember that Dunglison was himself but twenty-seven years old at that time. Those who find Mr. Jefferson's desire to pay for services rendered to him consonant with their own will be pleased to know that Dunglison did accept this single payment of \$50.00.

Emphysematous Gastritis Secondary to Acid Ingestion in an Infant

A. R. Jensen, M.D., and B. M. Rodgers, M.D.

ABSTRACT: Accidental ingestion of strong acids characteristically spares the esophagus and results in caustic injury to the stomach. A case is presented of a 16-month-old child with acid ingestion with the development of emphysematous gastritis. The resulting scarring of the antrum and pyloric regions of the stomach required gastric drainage with a gastroenterostomy. This child suffered severe nutritional complications with a limited gastric reservoir and hematologic complications of vitamin B₁₂ and folic acid deficiency. Evaluation and treatment of the hematologic complications is described. The patient achieved excellent nutritional improvement following construction of a Hunt-Lawrence gastrojejunal pouch.

Case Report

Emphysematous gastritis resulting from ingestion of acid is characterized by gastric dilatation, diminished peristalsis, delayed emptying, loss of mucosal integrity and interstitial emphysema. Gastric necrosis may result in perforation or heal with contraction and outlet obstruction. Surgery becomes necessary immediately if perforation occurs and later if stricture of the pylorus and antrum develops. With perforation, total gastrectomy may be necessary if the entire stomach is necrotic.¹ Strictures with outlet obstruction may be treated by partial or total gastrectomy or gastrojejunostomy.²

The following case is reported to illustrate the natural history of acid injury to the stomach in a 16-month-old child. The characteristic features of emphysematous gastritis occurred, followed by severe stricture of the pylorus and antrum. Gastrojejunostomy was performed. This was later converted to a Hunt-Lawrence jejunal pouch. This case also illustrates several of the postgastrectomy complications seen in children.

A 16-month male was admitted to a local hospital on 12/6/69 following the accidental ingestion of a soldering flux. Syrup of Ipecac was administered followed by lavage of the stomach with water. Vital signs on admission were temperature 37°C, pulse 128/min, respirations 12/min, and blood pressure 100/71. His mouth contained small amounts of bloody mucous and the posterior pharynx was erythematous. The patient was semicomatose and had grunting respirations. A chest x-ray showed a right upper lobe pneumonia. Initial treatment consisted of administration of intravenous fluids, Solu-Cortef and ampicillin. Mental clearing occurred within 48 hours. On the third day, a plain x-ray of the abdomen showed distention of the stomach with a radiolucent line in the wall, indicating the presence of emphysematous gastritis (Fig. 1). An upper gastrointestinal series on the fourth day revealed a normal esophagus with dilated stomach, loss of mucosa, interstitial emphysema, and edema of the pylorus and antrum. The gastric interstitial emphysema did not disappear radiologically until the 13th day following ingestion. The patient took feedings poorly and required supplementary intravenous fluids. On the 20th day, an upper gastrointestinal series showed flattened gastric mucosa, absent gastric peristalsis, rigidity of the antrum and delayed passage of the barium into the duodenum. The child continued to eat poorly with frequent vomiting. His weight fell from 13.6 kg on admission to 9.1 kg by the 24th day. Gastrointestinal series at this time showed marked constriction of the pylorus (Fig. 2). On the 27th day (1/2/70) abdominal exploration was performed. The stomach was contracted and adherent to the left lobe of the liver and diaphragm. The gastric wall was thick and felt rigid to palpation. The mucosa was extensively ulcerated and the pylorus stenosed. An anticollic gastrojejunostomy was performed. The postoperative course was unremarkable and he was discharged to home ten days later with a weight of 10.5 kg. Two additional short hospitalizations were

From the Department of Surgery and Pediatrics, University of Florida College of Medicine, Gainesville.



Fig. 1.—Lateral abdominal radiograph 72 hours following ingestion demonstrating air within the wall of the greater curvature and over the fundus of the stomach (arrows).



Fig. 2.—Gastrointestinal radiograph on the 24th postingestion day demonstrating severe narrowing in the region of the gastric antrum and pylorus (arrow). There was considerable delay in gastric emptying at this time.

necessary within the next month because of vomiting. On each occasion gastrointestinal series showed the stomach to be contracted with narrowed pylorus but a properly functioning gastrojejunostomy.

The family moved away and returned one year later in April 1971. His weight was still only 10.5 kg and he was eating poorly with frequent vomiting. The family refused further evaluation and did not return until November 1971. At this time, almost two years following the gastric injury, he weighed only 9.8 kg with a height of 84 cm. He was pale, weak and malnourished. The mother stated that he was not eating table food or blenderized foods but lived primarily on cola drinks, skim milk and bread.

Arrangements were made for transfer to Shands Teaching Hospital at the University of Florida, where he was admitted in December 1971. He was chronically malnourished with a weight of 9.5 kg (less than third percentile). The physical examination was unremarkable except for his extremely small stature. Laboratory evaluation revealed hematocrit of 11%, hemoglobin 3.1 gm %, and reticulocyte count of 0.4%. The serum iron was 215 mg/ml (normal 75-150), total iron binding capacity was 297 mg/ml (normal 250-350), and the iron saturation was 72% (normal 20-55). Red blood cell indices showed an MCV of 153 cu μ (normal 83-92), and MCH of 33 rr (normal 27-31), and an MCHC of 29% (normal 32-36). The peripheral blood smear was macrocytic and hypochromic. The bone marrow showed megaloblastic changes with erythroid hyperplasia. A serum B₁₂ level was 105 pg/ml (normal 200-900) and folate level was 6.9 ng/ml (normal 7-16). An oral first stage Schilling test was 8%, which was at the lower limit of normal. Total serum protein was 6.1 gm % and albumen was 3.8 gm %. Upper gastrointestinal x-rays disclosed an extremely small gastric reservoir with prompt emptying through the gastrojejunostomy. The patient was initially managed with frequent feedings of a low carbohydrate, high protein, high fat diet, and received intramuscular iron and vitamin B₁₂ therapy. He remained anemic at home on this regimen and was readmitted to Shands Teaching Hospital in July 1972. Hematologic studies then showed an hematocrit of 24%, hemoglobin 7.1 gm %, reticulocyte count 0.6% and a red blood cell count of 2.21 mil/cu mm. The serum B₁₂ level was low at 183 pg/ml as was the serum folate at 4.8 ng/ml. Bone marrow aspiration revealed megaloblastic changes with an ME ratio of 3:1. He was treated with intramuscular Infeon, vitamin B₁₂ and folic acid daily for 12 days. During this period the reticulocyte

count increased to 11.4% and hemoglobin to 9.2 gm %. His appetite improved markedly and he was discharged to home management. He received intramuscular folic acid and vitamin B₁₂ on a monthly basis over the following months.

In January 1975 he was readmitted to Shands Teaching Hospital for further study. His weight was 15.4 kg and height 100 cm, placing him below the third percentile for his age. The hematocrit was 36%, hemoglobin 11.8 gm % and white blood count normal. Gastric analysis revealed complete achlorhydria to Histalog and *Pseudomonas* was cultured from his gastric aspirate. Esophagoscopy and gastroscopy revealed no abnormalities in the epithelial lining of the esophagus except bile reflux and squamous metaplasia of the gastric remnant. It was believed this patient suffered from a small pouch syndrome as well as bile reflux gastritis and on 1/29/75 construction of a Hunt-Lawrence jejunal pouch was performed. Biopsies of the gastric fundus revealed edematous mucosa with nonspecific chronic inflammatory changes. Following this surgery, he has been able to consume a normal diet. In October 1975 his weight was 18.7 kg (third percentile) and height had increased to 106 cm (less than third percentile). The hematocrit was 35%, hemoglobin 11.2 gm %, and reticulocyte count 1.1%. The serum B₁₂ was 428 pg/ml and folate 53.5 ng/ml, both within normal limits. The Schilling test remains abnormal 18 months postoperatively.

Discussion

Soldering flux is a powerful corrosive, the active ingredient of which is zinc chloride, a strong acid. Characteristically, ingestion of acids spares the esophagus and injures the stomach, whereas lye and other alkalies may injure both the esophagus and stomach. Clearfield et al³ reported a case of lye ingestion in an adult causing both esophageal and gastric damage. Esophagitis resulted in esophageal stricture and emphysematous gastritis progressed to pyloric stricture. This patient was treated with a gastrojejunostomy and retrograde esophageal dilatation through a gastrostomy. Allen et al⁴ in 1969 reviewed the literature and found 159 cases of corrosive gastric injuries to which they added seven additional cases. Six of these cases resulted from ingestion of lye and one from formaldehyde. These authors emphasized that strong alkalies affect primarily the esophagus, but may damage the stomach in 20% of cases.

With the availability of the fiberoptic gastroscope, it is advisable to examine the esophagus and stomach of any person ingesting corrosive substances to determine as soon as practical the level and extent of damage.^{5,6} Acid burns of the stomach may be very mild and need no special treatment. The pylorus and antrum usually show the most severe damage, probably because pylorospasm results in retention of the acid longest in this region. Chung and DenBesten⁵ advised repeated fiberoptic endoscopy at 48 hour intervals to evaluate the extent of damage. These authors demonstrated that the diagnosis of full-thickness necrosis of the gastric wall may be made whenever black discoloration of the mucosa is encountered and recommended that surgery then be performed before frank perforation occurred. The usefulness of systemic steroids in these injuries is questioned but they may decrease subsequent scarring and stricture formation. In our case steroids were initiated to reduce cerebral edema from the heavy metals. However, when x-rays demonstrated the interstitial emphysema of the stomach wall, they were discontinued for fear that they would hasten perforation.

The origin of the intramural air in these injuries is unknown. Air may dissect into the damaged stomach wall from high gastric pressure secondary to pylorospasm or may form from gas producing bacteria directly invading the gastric wall. Han et al⁷ in 1965 stated that emphysematous gastritis is a variant of phlegmonous gastritis in which the infection in the gastric wall is due to gas-forming organisms. They found only eight cases in the literature and reported an additional case of a 44-year-old woman who developed emphysematous gastritis following ingestion of toilet cleaner containing 23% hydrochloric acid. The interstitial emphysema was discovered 13 days later with perforation occurring on the 14th day. Gonzales et al⁸ reported a spontaneous separation of the gastric mucosa as a necrotic cast shortly after acid ingestion. They emphasized that the gas bubbles in the stomach wall may persist for as long as one month. If the expertise is available, hyperalimentation should be considered in these patients if the stomach is severely damaged and they are unable to eat within a week or ten days.

The proper surgical treatment varies with severity of damage to the stomach. The maximal damage occurs at the pylorus and antrum and usually this tissue is too thickened with dense scar and edema to allow any form of pyloroplasty. Gastrojejunostomy or partial gastrectomy^{2,3} have

both been used successfully. In the patient described in this report, gastrojejunostomy appeared to be the safest and easiest procedure because of his precarious clinical state. In a more slowly developing pyloric stricture, in a healthier patient, a distal gastrectomy with either a Bilroth I or II anastomosis might provide a better long-time result. Total gastrectomy becomes necessary when the entire stomach is necrotic.^{1,7} In our patient the distal stomach was extensively damaged. The gastrojejunostomy relieved the obstruction, but the stomach was too contracted to function as more than a simple conduit, having no reservoir capacity.

The patient failed to thrive nutritionally, dropping to below the third percentile on the growth curve and megaloblastic anemia developed. He evidenced diminished vitamin B₁₂ and folate absorption secondary to caustic destruction of the normal gastric epithelium and diminished dietary intake. His hematologic parameters improved with the parenteral administration of vitamin B₁₂, folic acid and iron. Gastric analysis revealed histamine-fast achlorhydria which may have been on the basis of either caustic destruction of the parietal cell mass or severe bile reflux gastritis. Following construction of a Hunt-Lawrence jejunal pouch^{9,10} and diversion of his afferent limb to avoid bile reflux, the patient has been able to greatly increase the quantity of his diet. With the increased nutrition thus achieved and the supplemental vitamin B₁₂, folic acid and iron therapy, the hematologic parameters have improved to the normal range.

Summary

Emphysematous gastritis may result from accidental ingestion of acids. Perforation or total gastric necrosis may necessitate total gastrectomy. Usually the stomach heals with contraction and pyloric stenosis. If the disease involves primarily the pylorus and antrum, distal gastrectomy or gastrojejunostomy is effective treatment. However, when the entire stomach is scarred, construction of a Hunt-Lawrence jejunal pouch may offer a better opportunity for normal growth. Careful observation of hematologic parameters must be performed as these patients may develop evidence of vitamin B₁₂ and folate malabsorption and these vitamins should be administered with the earliest signs of malabsorption.

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Cracker Cures

Rupture

Split the trunk of an oak tree and pass the ruptured child through the split tree for a cure. Can also be cured by passing child through the fork of an oak tree.

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Percutaneous Stereotaxic Radiofrequency Lesions for Trigeminal Neuralgia

Albert L. Rhoton Jr., M.D., Jack E. Maniscalco, M.D.,
H. Victor Hoagland, P. A., and Bonnie Dale Chorvat, R.N., M.S.

Abstract: Percutaneous stereotaxic radiofrequency lesions of the trigeminal ganglion and root were performed in 149 patients for relief of trigeminal neuralgia. The procedure was done by introducing a needle electrode through the foramen ovale into the desired position using radiologic control and the conscious patient's response to electrical stimulation. The patient's cooperation was obtainable while using diazepam (Valium) to produce sedation and relaxation. Brief unconsciousness for the painful parts of the operation was produced by intravenous methohexital (Brevital). Of 149 patients treated, 146 obtained immediate relief of pain. During the period of follow-up ranging from one to 53 months, 28 patients (18.7%) had recurrence of pain. Eighteen patients had repeat procedures. In a total of 169 procedures, there had been no mortality. Undesirable postoperative side effects include analgesia extending beyond the involved division (15), trigeminal motor deficit (90), paresthesias in the numb area (50), and anesthesia dolorosa (20). Only one patient experienced neurological morbidity outside the trigeminal nerve, a sixth cranial nerve palsy, and this was transient. The procedure overcomes the need for a prolonged general anesthetic and major surgery, offers the possibility of permanent relief, and is easily repeatable. For patients wanting to avoid facial numbness, we recommend a vascular decompressive procedure involving a direct surgical approach to the trigeminal nerve.

Trigeminal neuralgia, a syndrome of paroxysmal pain involving the face, is also called "tic douloureux." It is possibly the most excruciating pain known to man. Routine pain medications are ineffective. Dilantin may help but the most effective drug is Tegretol. When these drugs fail, other means of treatment are needed. Peripheral neurectomy and alcohol injections may be tried but usually give

only temporary relief lasting an average of 8-16 months because the lesion, being peripheral to the ganglion, allows the nerve to regenerate. Permanent relief usually requires permanent denervation of the involved area. This has been accomplished most frequently by partial section of the trigeminal nerve through a subtemporal or suboccipital craniectomy utilizing general anesthesia. The characteristic elderly age of those afflicted, high incidence of associated medical conditions complicating the general anesthesia risk and possibility of injury of the facial or extraocular nerves with these intracranial surgical procedures prompted the search for other means of treatment.

Stereotaxic radiofrequency lesions of the posterior trigeminal root met this need by offering the possibility of permanent relief because the lesion is in the ganglion or posterior root. It requires only brief, several minute, periods of unconsciousness, is easily repeatable, and is only rarely associated with injury to other parts of the nervous system. The term "percutaneous" means that the procedure is done with a needle passed through the skin. The term "stereotaxic" refers to the fact that the needle is directed by x-ray control, and "radiofrequency" refers to the radiofrequency heating current which is used to destroy the nerve. The procedure was introduced in this country by Sweet¹ at the Massachusetts General Hospital.

The purpose of this paper is to review our experience with 149 patients treated by this method between July 1, 1972 and November 1, 1976. The follow-up period ranged from one to 53 months.

Clinical Characteristics

Age

Over half the patients in this series were over age 60 at the time of onset of pain and over age 65 when they were referred for this treatment (Table 1). Patients below age 50 with trigeminal neuralgia often had CAT scans or other neuroradiological procedures to rule out a tumor as the cause of the trigeminal neuralgia because of the increased

incidence of compressive lesions in the younger patient with this type of pain.

Table 1.—AGE FACTORS

Age Group (Years)	Age at Onset of Trigeminal Neuralgia	Age at Time of Radiofrequency Lesion
	Number of Cases	Number of Cases
Under 30	2	0
30 - 39	12	1
40 - 44	7	4
45 - 49	11	7
50 - 54	17	9
55 - 59	22	15
60 - 64	29	25
65 - 69	23	36
70 - 74	13	19
75 - 79	9	19
80 +	4	14
TOTAL	149	149

Location of Pain

As expected, third division pain was the most common and first division the least. More than half the patients had two or more divisions involved (Table 2).

Table 2.—DIVISIONS OF FIFTH CRANIAL NERVE INVOLVED.

Division Involved	Number
V ₁	4
V ₂	22
V ₃	44
V ₁ ' V ₂	27
V ₂ ' V ₃	63
V ₁ ' V ₂ ' V ₃	9
TOTAL	169

Prior Treatment

Patients were referred after they had received a trial of medical treatment with Tegretol or Dilantin and other means of treatment had failed (Table 3). Twenty-five patients had a recurrence of pain after a previous intracranial surgical procedure and 63 had received alcohol injections. Two patients had prior attempts at radiofrequency lesions.

Table 3.—PRIOR TREATMENT.

Number of Patients	
Medical	
Tegretol	131
Dilantin	92
Other	8
Intracranial Surgery	25
Alcohol Injection	63
Previous RFL (elsewhere)	2

Procedure

The procedures were done in the x-ray department with an anesthesiologist monitoring the patient. The procedure was facilitated by mild sedation produced by small doses of intravenous diazepam (Valium). Innovar was used for the initial patients; however, many complained of marked anxiety and restlessness following the procedure. This was not seen after we began to use Valium. A small amount of Xylocaine was infiltrated at the site of insertion of the radiofrequency needle. The needle was inserted 2 cm lateral to the corner of the mouth on the affected side, if the goal was to relieve third division neuralgia and 3 cm lateral for first and second division neuralgia (Figs. 1 & 2). With the head hyperextended and rotated slightly to the opposite side, the foramen ovale was identified using the image tube (Figs. 3 & 4). Brevital was given prior to passage of the needle through the foramen and during repositioning of the needle because both are very painful. Final needle position for creation of the lesion was selected based on the results of stimulation of the needle and lateral x-rays. For third division analgesia, a shallow needle position within the foramina ovale was needed. For analgesia of the second division, the tip of the needle was introduced a greater distance through the foramen and for analgesia of the first division, the needle tip was located as deep as the junction of the petroclinoid ligament and the posterior clinoid process (Fig. 5). No lesion was made until electrical stimulation produced paresthesias in the area of the trigeminal neuralgia. Lesions were made using radiofrequency current at 80-85 degrees C for 30-60 seconds. After each coagulation, the patient was awakened and sensory testing was done to determine the extent of analgesia. If the analgesia was less than desired, the patient was anesthetized again and the lesion enlarged. Some patients required four or five brief periods of electrocoagulation to obtain the desired facial



Fig. 1. — Drawing of face with cranial base and mandible superimposed. Electrode inserted lateral to mouth through foramen ovale (arrow).

analgesia. Patients were dismissed from the hospital the following day.

Results

Pain Relief and Recurrences

Of the 149 patients treated, 146 experienced immediate relief, but 28 patients (18.7%) subsequently had a recurrence. This compares favorably with the 22% recurrence in Sweet and Wepsic's² group of 274 patients and the 16 recurrences in 135 patients treated by Onofrio.³ Over half of our recurrences occurred in less than one month and many of these were patients who had requested that small lesions, causing minimal analgesia be done to determine if they could tolerate facial analgesia. Some patients find facial numbness very disagreeable. Patients were informed that the less the loss of pain sensation, the higher the recurrence rate. Eighteen patients had a second radiofrequency lesion to provide the analgesia needed for relief. A review of the literature indicates that the expected recurrence rate varies between 18-25% if analgesia is dense.³ This

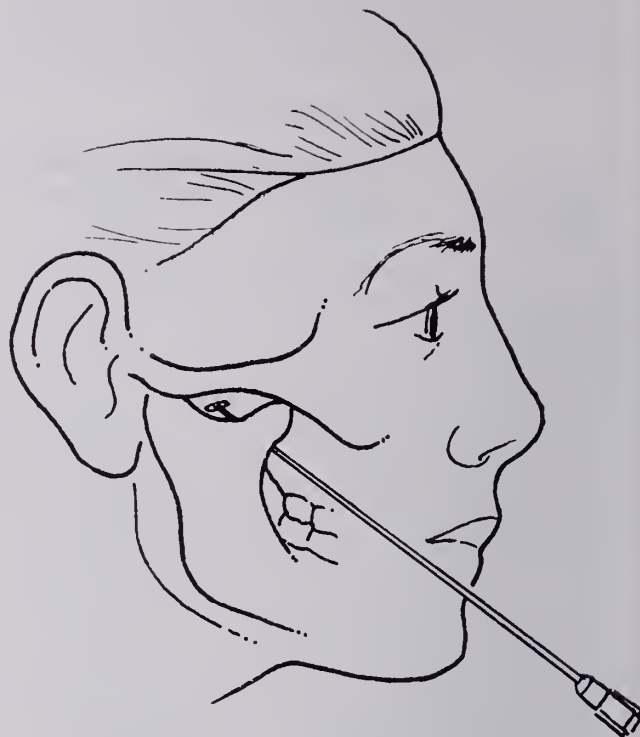


Fig. 2. — (A) Lateral view of placement of electrode.

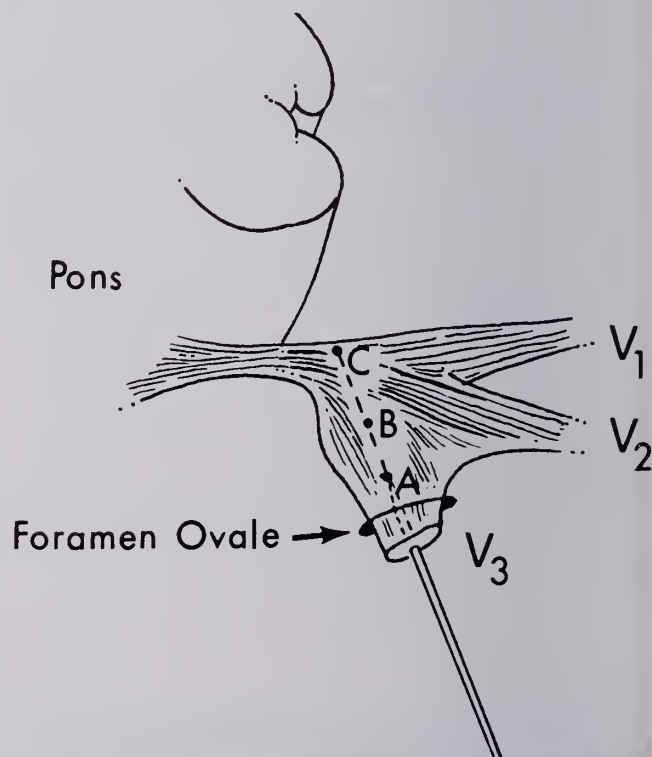


Fig. 2. — (B) Illustrates how advancing the electrode alters the divisional analgesia produced with the lesion. Third division analgesia is produced with the electrode near the foramen ovale (A); second division analgesia with the needle in an intermediate position (B); and first division analgesia is obtained with needle at (C).

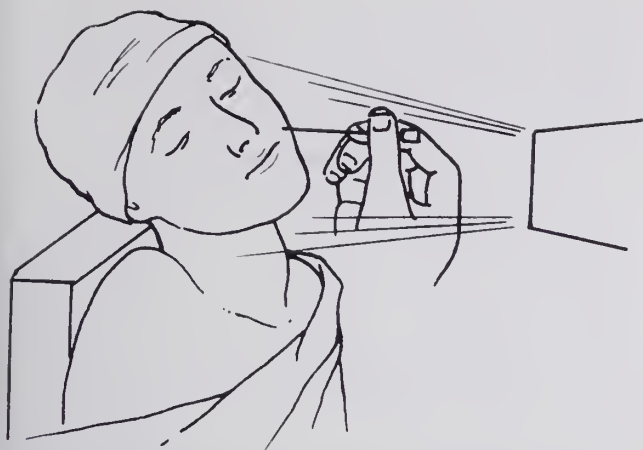


Fig. 3. — Optimal position for visualization of foramen ovale on fluoroscopy. Neck extended by allowing head to hang over edge of a four inch thick pad and head rotated slightly to the opposite side.

approximates the recurrence rate in this series. This is about twice the recurrence rate following craniotomy and intracranial nerve section.³

Whatever the recurrence rate, Stowsand and associates⁴ summarized the issue succinctly; they justified the 53% recurrence rate in their series following partial coagulation of the ganglion on the basis of the ease of repeating the procedure.

Undesirable Side Effects

Troublesome Paresthesias and Anesthesia Dolorosa. Fifty patients were mildly annoyed by paresthesias in the area made analgesic by the procedure (Table 4). This is best described as the sensation experienced after injection of local anesthetic for a dental procedure. Patients described the numbness with many different terms. Some common examples are that it "tingles," "burns," "pulls," "crawls," or is "woody," "stiff," or "like cement." Although many patients were annoyed by the paresthesias, they acknowledged they gladly accepted them for pain relief.

Twenty patients experienced spontaneous pain in the numb area. This pain in an analgesic area is referred to as "anesthesia dolorosa" (Table 4).



Fig. 4. — (A) View of right foramen ovale (arrow) using x-ray projection shown in Figure 3.



Fig. 4. — (B) Coagulation needle inserted through foramen ovale (arrow).



Fig. 5. — (A-C) Lateral views of typical needle placement for lesion of each division. Needle shallow in foramen for third division lesion, deep for first division and in intermediate position for second division. (A) Needle position for third division lesion. (B) Position for second division lesion. (C) Position for first division lesion.

Fifteen rated this pain as mild and another five patients called it severe. Only two patients felt that this pain equaled the severity of the trigeminal pain which had been treated.

Table 4.—UNDESIRABLE SIDE EFFECTS.

Motor Deficits	
Slight	67
Moderate	20
Severe	3
Troublesome Paresthesias	
Mild	29
Moderate	8
Severe	13
Anesthesia Dolorosa	
Mild	15
Severe	5
Unwanted Anesthesia	
One division	13
Two divisions	1
CN VI Palsy	1

Unwanted Analgesia. Spread of analgesia to divisions other than those affected by the pain occurred in 15 patients, an incidence approximating that of Sweet and Wepsic.² The most serious side effect of unwanted numbness is that affecting the first division and causing a loss of corneal sensation. Patients with this deficit may develop neuroparalytic keratitis and loss of sight due to corneal scarring as occurred in one of Sweet and Wepsic's cases.² This has not occurred in our patients; however, prior to the procedure, we warn patients about this and give them written instructions that they should contact an ophthalmologist at the earliest visible sign of irritation of the eye on the side of the lesion. Onofrio obtained unwanted first division analgesia in 10 of 135 patients.² The risk is greater in patients with second than with third division neuralgia. With first division neuralgia, the goal is to produce analgesia in that division.

Neurologic Complications. In 169 procedures, there was one case of neurologic injury outside the trigeminal nerve. It was a sixth cranial nerve palsy with resulting diplopia which was resolving rapidly six months after the procedure. Onofrio's case resolved in six months.³ Another complication not seen in our cases but present in other series is carotid artery puncture during the procedure.² A

hemiplegia followed carotid artery puncture in Rish's case.⁵

Motor Weakness. Weakness of the muscles supplied by the trigeminal motor root is common following radiofrequency procedures. Most patients do not notice the weakness. The motor root lesion, in contrast to that in the sensory root lesion, is distal to the motor nerve cell which is in the brain stem (the sensory nerve cell is in the ganglion) so the tendency for regeneration is great. The motor weakness usually resolves in six to nine months. Slight motor weakness was detected in 67 patients. Moderate weakness was present in 20 and three had severe weakness. Onofrio³ noted that of 56 patients with trigeminal motor weakness only two patients had symptoms related to it. Sweet and Wepsic² noted that over half their patients had trigeminal motor weakness following the nerve procedure. They felt that special attention to conserving that function was important only in patients with bilateral trigeminal neuralgia because the potential for motor recovery was great. The more lateral the needle is placed within the foramen, the more likely the lesion is to be purely sensory and if the needle is moved medially, there is a tendency to obtain more motor weakness.

Discussion

When medical therapy fails, one would like to offer a surgical procedure for trigeminal neuralgia that would give a high rate of permanent cure with no mortality, low morbidity, and as little sensory deprivation as possible. Kirschner⁶ introduced coagulation of the Gasserian ganglion in 1925, but technical problems and complications of the procedure caused it to fall into disrepute. It was not used in this country until repopularized by Sweet¹ who showed it to be safe and effective. Neither age nor debility is an absolute contraindication to the procedure. There has been no mortality and only

one case of morbidity outside the trigeminal nerve in 149 patients and this was transient.

The recurrence rate is greater than following craniotomy but this is justified on the basis of the ease of repeating the procedure. Postoperative trigeminal motor deficits usually recover. This experience has shown radiofrequency coagulation of the Gasserian ganglion and posterior root to be a safe and effective mode of treatment of trigeminal neuralgia.

The use of Valium instead of Innovar prior to the procedure has reduced postoperative anxiety, and the use of Brevital anesthesia during introduction and repositioning of the needle reduces the discomfort of the procedure over that experienced in other series^{2,3} in which Brevital was used only during coagulation of the trigeminal root and ganglion.

The procedure is the ideal procedure for the elderly patient wanting to avoid a major operative procedure in order to obtain permanent relief from trigeminal neuralgia. The main side effects have been related to facial numbness. For the younger patient who wants to avoid numbness, we recommend a vascular decompressive procedure requiring a suboccipital craniectomy and direct surgical exposure of the trigeminal nerve.

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- Dr. Rhoton, Box J-265 Health Center, University of Florida, Gainesville 32610.

ORGANIZATION



Chandler Alton Stetson Jr., M.D.
1921 - 1977

Chandler Alton Stetson Jr., M.D., Dean of the College of Medicine and Vice President for Health Affairs at the University of Florida, died on May 25 in Gainesville. He was 55.

Dr. Stetson came to Florida as Dean in 1972 from his previous post as Professor and Chairman of the Department of Pathology at New York University School of Medicine. Two years later, he was appointed to additional duties as Vice President for Health Affairs, and he held the dual positions until his death.

A native of Boston, Dr. Stetson attended Bowdoin College, where he graduated with honors in 1941. He received his M.D. degree from Harvard Medical School in 1944.

He took his internship at Boston Children's Hospital and residency training in pathology and pediatrics at Maine General Hospital.

An acknowledged world leader in the biomedical sciences, Dr. Stetson was a prolific contributor to the scientific literature and served on

the editorial boards of *Cancer Research*, *Annual Review of Medicine*, *Laboratory Investigation* and *The Journal of Experimental Medicine*. He served as a consultant and a member of various committees of such organizations as the American Cancer Society, National Board of Medical Examiners, the Sloan-Kettering Institute for Cancer Research, and others.

His many professional memberships included Alpha Omega Alpha; American Society for Clinical Investigation; the American Society for Experimental Pathology and the American Association of Pathologists and Bacteriologists, both of which he had served as President; the Association of American Physicians; and the Florida Medical Association.

Militarily, he served as an Ensign in the U.S. Navy, 1943-45; and as a Medical Corps Captain in the U.S. Army, 1951-53.

Dr. Stetson leaves his widow, the former Betty Jean Dill, and four daughters.

A Friend

In the fullness of his life, a great friend of the Florida Medical Association has fallen.

The phrase physician — scientist — educator applied to very few individuals as well as it did to Al Stetson. His career brilliantly encompassed all these roles, and in each he had merited and received great acclaim.

Since his arrival in our state to assume initially the position of Dean of the College of Medicine, and later also the role of Vice-President for Health Affairs at the University of Florida, he rapidly established as a high priority his becoming a part of the fabric of organized medicine.

On every occasion, and in all forums, he nurtured the concept of an effective linkage between medical education and the practicing physician. In the midst of his many duties, and in spite of the impingements on his schedule by the pressures of his position, he always took time to enhance his friendships with many members of our Association. Indeed, he looked forward to making new friends. This he accomplished with verve and zest, and transmitted to all his enthusiasm for life, his love for his friends, and his impeccable credentials as a person. The core of Al Stetson was the purest of gold.

Those who knew him will have their own memories, and each of us will retain certain vignettes of the past that were shared between two individuals.

For those of us who both knew him and loved him, who can forget

- His boy-like playfulness and enthusiasm for sport at the Board of Governors' meeting in Barbados.
- His carrying a pink garment bag on his shoulder through various transportation terminals on the way to a meeting in Homestead, Virginia, an act which rescued the shattered image of the Editor

who, while packing the car, had left all his wife's dresses on the driveway of their home.

- The wonderful delight with which he and Joe Von Thron planned the awarding of the honorary degree to our esteemed Executive Vice President.
- His abhorrence for all forms of injustice, however slight, to individuals in all echelons of society.
- The wonderful enthusiastic smile and firm handshake that were ever present when greeting people.
- His dedication and loyalty to his friends.
- The ultimate consideration with which he handled all human relationships.
- His kindness and courtesy to the staff of any organization with which he was associated. They, in return, reciprocated.

Through every phase of his life, he lived it to the fullest. He had absolutely no desire to retire, no wish to accept a position of less responsibility and stress, and no thought of diminishing his involvement in any of his activities. He was committed to the concept of maximal involvement during every day that he was privileged to live.

Florida became his adopted state; and he particularly loved its lakes and shores. Jointly he owned a small island off Cedar Key. It was there that he gained repose, recharged his psychological batteries, and enjoyed the wonders of nature — for him a life long fascination. Now, his ashes are spread over this same small island — to symbolize his alliance with the sanctuary on which he and his wife Betty spent many wonderful hours together.

The scene grows dim, and the imagery becomes cloudy as tears form in my eyes, and as Al Stetson fades from view but not from our hearts.

The Editor

May 25, 1977

Today Al Stetson died and for every Florida physician there has been a real and personal loss - a diminution in our overall professional completeness and unity. The FMA has suffered a blow that will leave a deep and permanent scar.

Al was an academician in the finest and fullest sense, but he was a physician and a warm, generous, dedicated human being above that. With his lean school boy's disarming charm and gentleness he, in a few short years, wooed and won the physicians of Florida - the University faculty and the State Legislature. Because he liked them, they liked him and found in him true integrity and dedication. The FMA, the University of Florida, and the entire state have all suffered an irreparable loss in his untimely death. He was a real giant in our profession and one who will never be replaced in our hearts - a truly beloved physician.

Jere W. Annis, M.D., Vice Chairman
AMA Board of Trustees
Lakeland

TO: W. Harold Parham, D.H.A.
Executive Vice President
Florida Medical Association

The AMA joins the physicians in Florida in expressing its profound sorrow and grief at the untimely death of our beloved physician, Doctor Al Stetson.

Dr. Stetson was a leader in academic and organized medicine and through a most unusual combination of personal and professional attributes, exemplified the growing cooperative alliance and fraternity within the AMA between the primary deliverers of medical care and the teaching facilities. He saw all doctors as one professional entity and he worked unceasingly to promote our mutual goals. He was a kind, gracious, scholarly gentleman whose equal we shall seldom see.

We salute his many accomplishments as a Dean, a physician and especially as a man; and we are inconsolable in his loss.

AMA Board of Trustees and Officers
May 26, 1977

Florida Medical Schools Award 299 M.D. Degrees

Clad in traditional doctoral academic gowns, nearly 300 young men and women stepped forward to receive their credentials as doctors of medicine at June Commencement exercises of Florida's three medical schools.

At the University of Miami, where the new physicians recited the Prayer of Maimonides rather than the traditional Hippocratic Oath, University of Miami President Henry King Stanford handed out 122 diplomas. Dean Emanuel M. Papper, M.D., was the principle speaker.

With 64 new physicians, the University of South Florida at Tampa doubled last year's class size. Acting Dean Hollis G. Boren, M.D., presented diplomas to 54 men and 10 women, while former Dean Donn L. Smith, M.D., presented the academic hoods.

South Florida's Commencement speaker was John M. Thompson, M.D., Clinical Associate Professor of Anatomy.

In Gainesville, University of Florida President

Robert Q. Marston, himself a medical doctor, conferred 113 M.D. degrees, seven of them with honors. Acting Dean William B. Deal, M.D., presided, and the Commencement address was presented by Dr. Lewis Thomas, President of the Memorial Sloan-Kettering Cancer Center.

The new physicians from Miami bring the number of UM medical school graduates to 1,858 since the first Commencement in 1956. Most practice in Florida.

Miami's Commencement also featured the award of an honorary Doctor of Science degree to New York philanthropist Joseph L. Mailman. With his brother, Abraham of Hollywood, Fla., Mailman heads the Mailman Foundation for which Miami's Mailman Center for Child Development is named.

South Florida's graduating class was its fourth and largest to date. It was an all-Florida class, with eleven graduates coming from the Miami area, seven from Tampa, five from St. Petersburg, nine from the Orlando area and four from the Fort Lauderdale area.

FLAMPAC Presents Special Awards At Annual Meeting Luncheon

The Florida Medical Political Action Committee (FLAMPAC) presented three special awards during the 103rd Annual Meeting of the Florida Medical Association at Bal Harbour.

Recipients were Rufus K. Broadaway, M.D., of Miami, former President of FLAMPAC; Francis C. Coleman, M.D., Tampa, FLAMPAC Treasurer; and W. Harold Parham, D.H.A., Jacksonville, Executive Vice President of FMA.

In addition, the Alachua County Medical Society received an award for the highest percentage FLAMPAC membership increase in 1976.

Dr. Broadaway, who headed FLAMPAC in 1974-76, was cited for "his deep conviction that medicine is a vital and invaluable part of our American Society and of the world of humanity and his refreshing enthusiasm and unusual skills in stimulating his colleagues to believe and participate in the American political system."

Dr. Coleman's award cited "his unselfish devotion to the preservation of the practice of medicine by political involvement and his unbending belief that medicine stands as a cornerstone to the preservation of American Democracy."

Dr. Parham was recognized for "his vigorous, energetic and local support to Medicine, the doctors of Florida and their involvement in the American political system, 1949-1977."

FLAMPAC President John W. Glotfelty, M.D., Lakeland, presented the awards at the annual Auxiliary-FLAMPAC Luncheon at the Americana Hotel on Friday, May 6. The luncheon speaker was Mr. Richard M. Scammon, Director of the Elections Research Center in Washington, D.C.

Current officers of FLAMPAC are: Dr. Glotfelty, President; William W. Thompson, M.D., Ft. Walton Beach, Vice President; John W. Hamilton, M.D., St. Petersburg, Secretary; Dr. Coleman, Treasurer, and Dr. Parham, Assistant Treasurer.

John W. Glotfelty, M.D., Lakeland, President of FLAMPAC, presents awards to Rufus K. Broadaway, M.D., Miami, former President of FLAMPAC (upper photo); Francis C. Coleman, M.D., Tampa, FLAMPAC Treasurer (second from top); and W. Harold Parham, D.H.A., Jacksonville, FLAMPAC Assistant Treasurer and Executive Vice President of FMA (second from bottom). In bottom photo, Taylor H. Kirby, M.D., Gainesville, accepts for the Alachua County Medical Society a citation for having the highest percentage FLAMPAC membership increase in 1976.



Dr. Eugene G. Peek Jr., Re-Elected Foundation President

Eugene G. Peek Jr., M.D., of Ocala, was re-elected President of the Florida Medical Foundation at a meeting of the Foundation's Board of Directors at the Americana in Bal Harbour on May 8.

Other officers elected to serve during the coming year are: Theodore J. Marshall, M.D., Pensacola, Donald G. Nikolaus, M.D., Dunedin, and Thomas B. Thames, M.D., Orlando, Vice Presidents; and W. Harold Parham, D.H.A., Jacksonville, Secretary-Treasurer.

The Board organized after members were reappointed by the FMA Board of Governors.

The Foundation was established in 1956 by the FMA House of Delegates. Its objectives are to sponsor graduate and postgraduate medical education; provide financial assistance for medical students; promote and sponsor medical research, and assist indigent and destitute physicians.

FMA Public Relations Institute Scheduled for September

The Florida Medical Association will conduct a Public Relations Institute, featuring seminars on negotiations, speaking, and public relations, in Tampa in September.

The three-in-one meeting will get under way with the first part of an AMA Negotiations Seminar at 1:30 p.m. on Friday, September 16, at the Holiday Inn Airport. Limited to 30 participants, the Negotiations Seminar will continue Saturday and Sunday mornings, September 17-18.

An FMA Speakers Seminar will begin Saturday morning, run to noon, and resume Sunday morning. Registration is limited to 25.

Saturday afternoon will be devoted to the Public Relations Seminar.

Information may be obtained by contacting the Public Relations Department, Florida Medical Association, P.O. Box 2411, Jacksonville, Florida 32203.

Former Journal Consultant, Mrs. Edith Hill, Dies

Mrs. Edith B. Hill, 85, who worked for almost 30 years as Editorial Consultant to *The Journal of the Florida Medical Association*, died in Jacksonville on June 20 after a long illness.

A native of Niles, Mich., Mrs. Hill moved to Jacksonville about 40 years ago and joined *The Journal* in 1939 under the editorship of the late Shaler Richardson, M.D., of Jacksonville. From then to her retirement she served under two other editors — Thad Moseley, M.D., of Jacksonville, and Franz H. Stewart, M.D., of Miami—and several managing editors.

In her 29-year association with *The Journal*, scarcely an item appearing in these pages escaped her notice and her sharp pencil. A smooth uniform grammatical style that made its first appearance in *The Journal* in 1940 was attributed to her.

"Through the years all published information has profited from her study, and many members of our Association, with her guidance, have become better writers and speakers," Editor Moseley wrote in 1966.

Two years later, her health failing, Mrs. Hill retired. Prior to her retirement the FMA Board of Governors cited her for "her untiring pursuit of literary and scientific excellence in behalf of the Florida Medical Association and the medical literature."

She leaves a stepdaughter and two cousins.



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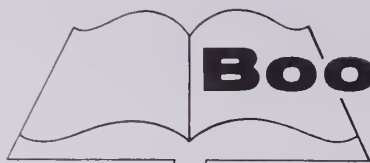
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Dorothy R. Mooney, Associate Director



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ACCREDITED BY THE J. C. A. H.



Book Reviews

Book Review Editor

F. Norman Vickers, M.D.

Clinical Methods: The History, Physical and Laboratory Examinations by H. Kenneth Walker, M.D.; W. Dallas Hall, M.D. and J. Willis Hurst, M.D. Vol. I - 420 Pages, Price \$12.00. Vol. II - 675 Pages, Price \$12.00. Both Illustrated. Butterworth, Inc., Woburn, Mass., 1976.

The faculty at Emory University has combined several of their student teaching manuals into an encyclopedic compilation of information dealing with the history, physical examination and laboratory evaluation of patients. The volumes are organized with each chapter assuming a similar form, beginning with a "Definition" and a description of the "Technique" of the particular examination. A section entitled "Background Information" provides useful physiologic basis for the various examinations and frequently includes pertinent points of historical interest. Each chapter is concluded by a discussion of the "Clinical Significance" of the examination or test described. A short, reasonably timely bibliography is included with each chapter. In general, the illustrations throughout this volume are well conceived and complimentary to the text.

Volume I begins with an excellent description of the problem-oriented medical record and proceeds with methods of taking a general medical history. The second of the two-volume set explains the various methods of physical examination and the evaluation of commonly ordered laboratory tests.

Reflecting the clinical interests of the editors, the book is weighed heavily toward evaluation of the cardiovascular system and provides an excellent description of pulmonary and cardiac diagnosis. The chapter dealing with examination of the female breast is also extremely thorough and very well illustrated.

These volumes should provide an excellent reference for medical students beginning their clinical experience and will give excellent assistance in the organization and performance of

the history and physical examination. The volumes will be of lesser use to the more advanced resident and practicing clinician.

Bradley M. Rodgers, M.D.
Gainesville

Dr. Rodgers is Associate Professor of Surgery and Pediatrics, Division of Pediatric Surgery, University of Florida College of Medicine, Gainesville.

Current Medical Diagnosis and Treatment by Marcus A. Krupp, M.D. and Milton J. Chatton, M.D. 1,066 Pages. Price \$16.00. Lange Medical Publications, Los Altos, California, 1977.

This volume is . . . "intended to serve the practicing physician as a useful desk reference . . .", and so it will. Somehow in my medical reading I failed to learn of the Lange Publishing Company. This outfit has good books on many subjects and only recently have I realized what I have missed. Their Immunology and Bacteriology (recently reviewed) impressed me with quality, quantity and price. So does this book. The authors review, in semi-outline form, not only things related to Internal medicine, but also surgical, endocrine, obstetrical and gynecologic disorders. I was especially struck by the approach to the diagnosis of thyroid disease and the Laboratory tests currently employed. Chemotherapy for malignant disease with a diagram illustrating - what you should use for what - impressed me. The language throughout is simple and direct, the recommendations appear to be based on reasonable practices, and the organization permits ready reference to weighty or light weighty problems. It's highly recommended.

Courtlandt D. Berry, M.D.
Ocala

Dr. Berry is a practicing Pathologist at Marion Community Hospital, Ocala.

Books Received

Receipt of the following books is acknowledged. Medical readers interested in reviewing particular books are invited to address requests to the Book Review Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.

Healthy Pregnancy — The Yoga Way by Judi Thompson (Foreword by James C. Baker, M.D.). 148 Pages. Illustrated. Price \$3.95. Doubleday & Company, Inc., Garden City, New York, 1977.

How to Feed Your Hyperactive Child by Laura J. Stevens, George E. Stevens and Rosemary B. Stoner. 240 Pages. Price \$7.95. Doubleday & Company, Inc., Garden City, New York, 1977.

Social Responsibility: Journalism, Law, Medicine, Volume II, edited by Louis W. Hodges. 104 Pages. Price \$2.50. Washington and Lee University, Lexington, Virginia, 1976.

Correlative Neuroanatomy & Functional Neurology, 16th Edition by Joseph G. Chusid, M.D. 448 Pages. Illustrated. Price \$10.00. Los Altos, California, Lange Medical Publications, 1976.

Current Pediatric Diagnosis and Treatment, 4th Edition, by C. Henry Kempe, M.D., Henry K. Silver, M.D. and Donough O'Brien, M.D. 1,053 Pages. Illustrated. Price \$15.00. Los Altos, Lange Medical Publications, 1976.

Current Obstetric & Gynecologic Diagnosis & Treatment by Ralph C. Benson, M.D. and Associate Authors. 912 Pages. Price \$16.00. Lange Medical Publications, Los Altos, Calif., 1976.

Growth, Maturation, and Aging by Tadayoshi Imaizumi. 118 Pages. Suginami-ku, Tokyo, Kagayama Press, 1976.

The Multiple Sclerosis Diet Book by Roy L. Swank, M.D., Ph.D. and Mary-Helen Pullen. 326 Pages. Price \$8.95. Doubleday & Company, Inc., Garden City, New York, 1977.

Currents in Alcoholism, Biological, Biochemical and Clinical Studies, Volume I edited by Frank A. Seixas, M.D. 495 Pages. Illustrated. Price \$19.50. New York, Grune & Stratton, 1977.

Currents in Alcoholism, Biological, Biochemical and Clinical Studies, Volume II edited by Frank A. Seixas, M.D. 548 Pages. Illustrated. Price \$19.50. New York, Grune & Stratton, 1977.

Southwestern Medical Dictionary, Spanish English, English Spanish, by Margarita Artschwager Kay with John D. Meredith/Wendy Redlinger and Alicia Quiroz Raymod. 217 Pages. Price \$3.75 (paper) \$9.50 (cloth). Tucson, Arizona, The University of Arizona Press, 1977.

BT Behavior Therapy, Strategies for Solving Problems in Living by Spencer A. Rathus, Ph.D. and Jeffrey S. Nevid, Ph.D. 314 Pages. Illustrated. Price \$8.95. Garden City, New York, Doubleday & Company, 1977.

Apostles and Prophets, Medicine for Society's Ills by Frederick Eberson, Ph.D., M.D., Author of Man Against Microbes. 106 Pages. Illustrated. Price \$6.00. New York, Exposition Press, 1977.

Income Redistribution, edited by Colin D. Campbell. 267 Pages. Price \$4.75 (paperback) \$9.75 (cloth). Washington D.C., American Enterprise Institute for Public Policy Research, 1977.

Doctors

Carolyn Kirkland Kenyon

You work with miracle drugs
and modern technology.
You work with tenderness
and the knife.
You cut out sickness,
stitch and bind wounds,
and recite prayers
to the weaknesses of the body.

You are not Gods,
though your patients often want you to be;
You are only human,
doing your best to mend other humans.

Some die.
They die young - fragile blossoms not yet opened
And they are the hardest to forget.
They die old -
Often alone - In the December of their years -
Still you care.

All along you remember -
Handle with care - heal.
You would make them all well
if you could.

Your successes, your cures
are "miracles" shared -
Your failures are pains that
you bear alone.

Ms. Kenyon is Executive Assistant to the FMA Executive Vice President.



A St. Lucie County Circuit Court Judge . . . has denied a motion for retrial of a Ft. Pierce physician's successful countersuit against a law firm.

But Judge Royce Lewis did reduce the award of \$175,000 granted to John B. Sullivan, M.D., to \$75,000 and gave him 10 days to accept the reduced amount or appeal.

Dr. Sullivan, an orthopedic surgeon, predicted that the favorable outcome of his lawsuit will result in the savings of millions of dollars for Florida consumers. "Every citizen of Florida, every businessman, every doctor should be encouraged by the verdict of this jury because its actions imply that an attorney must conform to a strict standard of care before filing suit against anyone for any reason," he added.

Dr. Sullivan was represented by Miami Attorney Ellis S. Rubin, who said:

"Although no appeal has been filed, the Sullivan decision by the circuit court jury says that the standard of care for a lawyer is this: Before filing suit, he must research the law and the facts to the extent that there is probable cause for filing a lawsuit against a potential defendant."

The verdict of May 27 was against the law firm of Fee, Parker and Fee, which had represented an accident victim Dr. Sullivan had treated in 1970. A malpractice suit was filed in 1971 against Dr. Sullivan, but it was dropped on the date scheduled for trial.

Dr. Sullivan's professional liability insurance was cancelled.

Leonard A. Lewis, M.D., of Miami . . . has been elected President of the Miami Dermatological Society for 1977-78.

Twelve Florida physicians . . . have been elected to Fellowship in the American College of Physicians. They are among 373 new Fellows elected at a recent meeting of the College's Board of Regents. The Floridians are: Allan L. Goldman, M.D., Brandon; Francis J. Tedesco, M.D., Coral Gables; Carroll L. Moody, M.D., Fort Lauderdale; Julio E. Ferreiro, M.D., Richard H. Pollak, M.D., James C. Pringle Jr., M.D., and Ruey J. Sung, M.D., all of Miami; Michael J. King, M.D., Miami Beach; Albert L. Kerns, M.D., Naples; Henry L. Harrell Jr., M.D., Ocala; Barry E. Sieger, M.D., Orlando; and Eric E. Harrison, M.D., Tampa.

The Institute of Kidney Diseases . . . at the University of Miami School of Medicine has received a \$100,000 grant from the Burroughs Wellcome Fund.

The grant will help support the Institute's multi-disciplinary approach to kidney disease, employing independent but collaborative efforts. The Institute, of which Neal S. Bricker, M.D., is director, plans a comprehensive center that will include research, teaching, diagnosis and treatment of kidney diseases.

Several Florida physicians . . . including FMA President-Elect O. William Davenport, M.D., of Miami, are among program participants for the Seventh Annual George Papanicolaou Memorial Seminar in Gynecologic Pathology.

The Seminar will be conducted on November 9 in Dallas, Tex., as part of the scientific program for the annual meeting of the Southern Medical Association.

George Ioannides, M.D., Miami Beach, is Director of the Seminar, and Dr. Davenport is Co-Director. Participants will include: Arkadi Rywlin, M.D., Miami Beach, pathologist; Hervy E. Averette, M.D., Miami, gynecologist; and Ivor Fix, M.D., Miami Beach, radiotherapist.

Papers to be presented include: "Adenomatoid Tumor of Corpus Uteri," Daniel Seckinger, M.D., Miami; "Actinomyces of the Ovary," Ronald M. Rhatigan, M.D., and Rosilie O. Saffos, M.D., Jacksonville; and "Histiocytic Lymphoma Presenting as a Pelvic Mass," James N. Alleyn, M.D., Miami.



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Deaths

Amerise, A. Daniel, Coral Gables; born 1898; Jefferson Medical College, 1922; member AMA; died January 2, 1977.

Anderson, Hildreth V. II, Fort Walton Beach; born 1912; Louisiana State University, 1954; member AMA; died May 1, 1977.

Carlisle, James M. Sr., Pensacola; born 1904; Temple University, 1932; member AMA; died May 16, 1977.

Carroll, Bruce D., Miami; born 1905; Vanderbilt University, 1934; member AMA; died April 25, 1977.

Converse, J. Gerard, Winter Haven; born 1918; Tufts University, 1943; member AMA; died February 5, 1977.

Diaz, Yara P., Fort Myers; born 1923; Havana University, 1952; member AMA; died January 27, 1977.

Donelan, Richard T., Jacksonville; born 1925; Tufts University, 1949; member AMA; died January 18, 1977.

Heldeman, John P., Fort Lauderdale; born 1935; University of Louisville, 1961; member AMA; died January 14, 1977.

Hoffmann, Carl D., New Smyrna Beach; born 1900; Emory University, 1924; member AMA; died January 10, 1977.

Jeiks, Edward, Jacksonville; born 1888; Johns Hopkins University, 1913; member AMA; died February 7, 1977.

Kauders, Ferdinand H., Miami; born 1912; University of Georgia, 1935; member AMA; died February 15, 1977.

Hahn, Charles S., Fort Lauderdale; born 1910; University of Maryland, 1937; member AMA; died Marych 1, 1977.

Lastra, Jose S., Miami; born 1901; Havana University, 1925; member AMA; died March 4, 1977.

Madden, Edward P., Daytona Beach; born 1902; Loyola University, 1930; member AMA; died January 4, 1977.

Marsteller, Daryl H., Jensen Beach; born 1930; Hahnemann Medical College, 1956; member AMA; died March 24, 1977.

Martin, John S., Oklawaha; born 1897; Boston University, 1925; member AMA; died March 21, 1977.

Martin, Stanley T., Sarasota; born 1904; University of Arkansas, 1933; member AMA; died February 11, 1977.

Matthews, A. Lamar Jr., Sarasota; born 1906; University of Georgia, 1932; member AMA; died April 14, 1977.

Montero, Angel, Tampa; born 1898; Havana University, 1922; member AMA; died March 25, 1977.

Moore, Harry M., Vero Beach; born 1909; Hahnemann Medical College, 1933; member AMA; died January 2, 1977.

Newman, Abraham L., Miami; born 1922; Virginia University, 1951; member AMA; died March 9, 1977.

Park, Charles L., Sanford; born 1900; Emory University, 1923; member AMA; died February 27, 1977.

Parramore, James B., Miami Springs; born 1886; University of Maryland, 1909; member AMA; died January 6, 1977.

Parrish, Bruce E., St. Petersburg; born 1929; University of Tennessee, 1957; member AMA; died April 27, 1977.

Rankin, Donald T., St. Augustine; born 1888; New York Homeo Medical College, 1914; member AMA; died January 28, 1977.

Schroer, Harry A., West Palm Beach; born 1916; Cornell University, 1945; member AMA; died February 9, 1977.

Shaw, E. Russell, South Miami; born 1922; University of Geneva, 1952; member AMA; died May 12, 1977.

Smith, James R., Orlando; born 1918; Meharry Medical College, 1944; member AMA; died February 20, 1977.

Stampa, Julian M. St. Petersburg; born 1921; Berlin Medical School, 1945; member AMA; died January 19, 1977.

Stetson, Chandler A. Jr., Gainesville; born 1921; Harvard University, 1944; member AMA; died May 25, 1977.

Stewart, Douglas J., Fort Lauderdale; born 1941; University of Miami, 1967; member AMA; died April 3, 1977.

Tomlinson, John P. Jr., Lake Wales; born 1901; Emory University, 1927; member AMA; died April 5, 1977.

Wallace, Stanley K., Lake Placid; born 1916; Jefferson Medical School, 1942; member AMA; died February 2, 1977.

Wood, Robert G., St. Cloud; born 1908; Tulane University, 1932; member AMA; died April 30, 1977.

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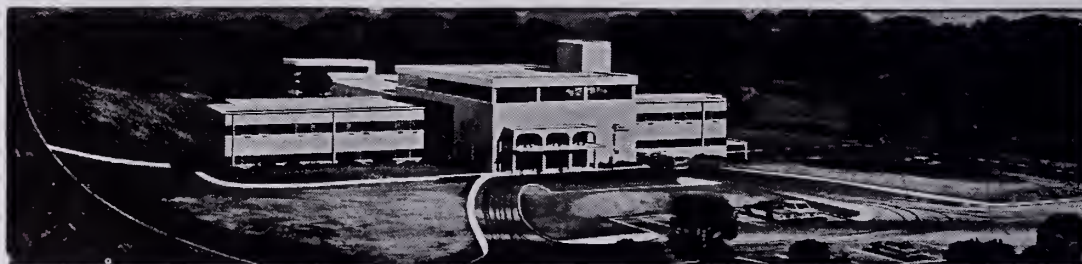
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FOURTH ANNUAL REVIEW COURSE

"Fundamental and Clinical Aspects of Internal Medicine"

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Miami, Florida

October 9-22, 1977

Directors: William J. Harrington, M.D., Eric Reiss, M.D., and Neal S. Bricker, M.D.

Program Coordinator: Jose S. Bocles, M.D.

This course is designed primarily for physicians who are preparing for initial certification or recertification in internal medicine. It will provide an intensive survey of those aspects of internal medicine which should be familiar to internists qualified for certification. Pertinent basic and core information followed by a survey of recent clinical advances needed for effective patient care will be presented. Printed texts, references and self-assessment questionnaires will be provided to all registrants, and audio-visual teaching aids will be available for self-instruction and reinforcement. This course will end one week prior to the recertification examination of the American Board of Internal Medicine, thereby providing time for assimilation.

Schedule

Week I — October 10-15, 1977

October	10	Gastroenterology & Hepatology
"	11	Cardiology
"	12	Hypertension & Body Fluids
"	13	Nephrology
"	14	Endocrinology
"	15	Oncology & Genetics

Week II — October 17-22, 1977

October	17	Hematology
"	18	Infectious Diseases & Immunology
"	19	Rheumatology
"	20	Pulmonary Diseases
"	21	Clinical Pharmacology, Dermatology, Toxicology & Environmental Medicine
"	22	Neurology & Psychiatry

Supervised CME Activities: 84 Hours Credit

As an organization accredited for continuing medical education, the University of Miami School of Medicine certifies that this continuing medical education offering meets the criteria for 84 credit hours in Category I of the Physician's Recognition Award of the American Medical Association, provided it is used and completed as designed.

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Registration Fees: Entire Course (Oct. 10-22) \$500
Week I (Oct. 10-15) \$300
Week II (Oct. 17-22) \$300
Per day (minimum of 3 days) \$ 70

Checks payable to: U/Miami Internal Medicine Review Course.

Minimum and maximum enrollment has been established for this course. Please register early. Registration is non-transferable.

In case of withdrawal, we require written notice before September 28, 1977. An administrative fee of \$25 will be charged for any refund made.

For information and application write to:

J. Bocles, M.D., Department of
Internal Medicine
University of Miami School of Medicine
P. O. Box 520875, Miami, Florida 33152
Phone: (305) 547-6063

*Includes tuition, set of 11 textbooks, use of audiovisual aids, library loan of T.V. tapes, cassette tapes and sets, and slides.

MEETINGS

Approved by FMA Committee on Continuing Medical Education

AUGUST

1977 Postgraduate Obstetric-Pediatric Seminar, Aug. 1-4, Don CeSar Resort Hotel, St. Petersburg Beach. For information: Emily H. Gates, M.D., 1323 Winewood Boulevard, Building 1, Tallahassee 32301.

Fluid and Electrolyte Balance, Aug. 8, Good Samaritan Hospital, West Palm Beach. For information: John C. Whelton, M.D., 1665 Palm Beach Lakes Boulevard, #602, West Palm Beach 33401.

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Aug. 8-13, Miami.*

SEPTEMBER

Current Treatment of Hypertension, Sept. 14, Peace River Country Club, Bartow. For information: Bernard Briter, M.D., Director, Medical Education, University of South Florida, Tampa 33620.

Medical Aspects of Aging, Sept. 30-Oct. 1, Gainesville, Hilton, Gainesville.**

25th Annual Seminar, American Diabetes Association, Florida Affiliate, Sept. 29-Oct. 2, Don Caesar Resort Hotel, St. Petersburg.

OCTOBER

Topics in Family Medicine, Oct. 3-7, Americana Hotel, Bal Harbour. For information: Elliott Podoll, M.D., P.O. Box 520875, Miami 33152.

Obstetrics and Gynecology Review Course, Oct. 8-14, Miami.*

Review Course on "Fundamental and Clinical Aspects of Internal Medicine", Oct. 9-22, Sheraton Four Ambassadors, Miami. For information: J. Bocles, M.D., Department of Medicine, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152.

Use and Abuse of Blood and Its Components, Oct. 11, Manatee Memorial Hospital, Bradenton. For information: Allen R. Sklerov, M.D., 525-3rd Street, East, Bradenton 33505.

Florida Urological Society annual fall meeting, Oct. 13-16, Ponte Vedra Club, Ponte Vedra. For information: Raymond J. Fitzpatrick, M.D., 706 S. W. 4th Ave., Gainesville 32601.

Obstetrics and Gynecology Review Course: Pathology Section, Oct. 15-16, Miami.*

OB-GYN Cystoscopy Course, Oct. 17-19, Miami.*

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Oct. 24-29, Miami.*

NOVEMBER

Fall Meeting of the Florida Society of Ophthalmology, Nov. 3-6, Sandpiper Bay, Port St. Lucie, Florida. For information: Susan Waits, Suite 400G, Barnett Bank Building, Tallahassee 32301.

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Nov. 7-12, Miami.*

Pars Plana Vitreous Surgery - The Miami Technique, Nov. 10-12, Miami.*

The Eye in Family Practice, Nov. 11-12, Miami.*

Clinical Application of the Intra-Aortic Balloon Pump, Nov. 25-27, Miami.*

DECEMBER

The Vitreous, Dec. 7-9, Miami.*

Pediatric Anesthesia, Dec. 8-11, Miami.*

Medical Surgical Seminar, Dec. 9-10, St. Francis Hospital, Miami Beach. For information: Lawrence R. Medoff, M.D., 250 West 63rd Street, Miami Beach 33141.

Intraocular Lenses, Dec. 12-15, Miami.*

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Dec. 12-17, Miami.*

1978

JANUARY

Fifth Annual Symposium in Pediatric Nephrology: Current Concepts in Diagnosis and Management, Jan. 4-7, Miami.*

Fifteenth Annual Postgraduate Seminar in Anesthesiology, Jan. 5-8, Americana Hotel, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

Miami Winter Symposia, Jan. 9-13, Miami.*

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Jan. 9-14, Miami.*

Third Annual Seminar, "Problems in Pediatric Radiology", Jan. 13-17, Miami.*

Post-Convention Seminar: Pediatric Radiology "Radiographic-Pathologic", Jan. 17-20, Miami.*

Art and Science in the Therapy of Difficult Problems in Surgery, Jan. 18-21, Miami.*

10th Annual Postgraduate Seminar in Pediatric & Adult Urology, Jan. 19-21, Carillon Hotel, Miami Beach. For information: Victor Politano, M.D., 3900 Northwest 79th Ave., Suite 469, Miami 33166.

Corneal and Plastic Ophthalmic Surgery and Diseases of the Eye, Jan. 22-27, Miami.*

3rd Annual Review and Recent Practical Advances in Pathology, Jan. 23-27, Miami.*

A Neurological Update: 1978, Jan. 23-27, Miami.*

Thirteenth Annual Scientific Assembly of the American Society of Contemporary Medicine and Surgery, Jan. 30-Feb. 3, Americana Hotel, Miami Beach. For information: John G. Bellows, M.D., 6 North Michigan Avenue, Chicago 60602.

FEBRUARY

Fourth Annual Fall Conference in Anesthesiology, Feb. 4-11, Miami.*

OB-GYN Caribbean Seminar, Feb. 4-11, Miami.*

Florida Midwinter Seminar in Ophthalmology, Feb. 6-8, Miami.*

13th Annual "Internal Medicine 1978", Feb. 6-11, Miami.*

Florida Midwinter Seminar in Otolaryngology, Feb. 9-11, Miami.*

Principles of Practice Management, Feb. 12-18, Miami.*

Basic Neurology for Psychiatrists, Family Practitioners and General Practitioners, Feb. 26-Mar. 3, Miami.*

MARCH

Hepatobiliary Disease in Clinical Practice, Mar. 2-4, Miami.*

3rd Annual Conference in Skin Disorders for Nurses, Mar. 3-5, Miami.*

Postgraduate Seminar in Dermatology, Mar. 3-5, Miami.*

Sixteenth Annual Clinical Radiology Seminar, Mar. 7-11, Miami.*

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Mar. 13-18, Miami.*

10th Teaching Conference in Clinical Cardiology, Mar. 22-25, Miami.*

Current Clinical Concepts in Otolaryngology - 1978, Mar. 22-24, Miami.*

APRIL

Malignant Hyperthermia, Apr. 6-9, Miami.*

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Apr. 10-15, Miami.*

Sixth Annual Intensive Care Symposium, Apr. 15-17, Miami.*

Emergencies in Internal Medicine, Apr. 17-20, Miami.*

MAY

Second Annual Symposium on Underwater Medicine, May 4-8, Miami.*

Post-Convention Seminar and Diving Program, May 8-11, Miami.*

Pars Plana Vitreous Surgery - The Miami Technique, May 11-13, Miami.*

Family Medicine Update - 1978, May 18-21, Miami.*

JUNE

Review Course for Certification in Internal Medicine, June, Miami.*

Bascom Palmer Eye Institute Alumni Meeting and Seminar, June 9-11, Miami.*

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WANTED: Physician to join several other physicians in emergency room practice in central Florida community hospital, 150 beds. Forty hour week. Benefits include 3 weeks vacation and 2 paid medical conferences. Starting salary \$40,000 yearly. Must be graduate of U.S. medical school, have AMA internship, and some previous practice desirable. Florida license necessary. Contact: James N. Kulpan, Administrator, Waterman Memorial Hospital, P.O. Drawer B, Eustis, Florida 32726. Phone: (904) 357-4161.

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INTERNAL MEDICAL PRACTICE in North Miami, Florida, available for sale. Write C-746. P. O. Box 2411, Jacksonville, Florida 32203.

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				Associate	Active
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Bakar (See Nasseu)					
Bay	Clark A. Whitehorn, Panama City	John Provan, Panama City	1st Tues	3	61
Bradford (See Alachua)					
Bravard	Leudie E. McHenry, Melbourne	Richard Baney, Melbourne	2nd Tues	21	216
Broward	Anthony J. Vento, Plantation	William C. Hartley, Hollywood	4th Tues	162	1045
Calhoun (See Penhandle)					
Capital	Alvie C. McCully, Tallahassee	William E. Price, Tallahassee	2nd Mon	43	189
Charlotta	Riazin Imami, Port Charlotte	Stephen R. Roddy, Charlotta Harbor	2nd Mon	2	73
Citrus-Hamando	R. E. Dodge, Inverness	J. R. Berrios, Brooksville	3rd Thurs	1	45
Clay	Robert M. Sladak, Orange Park	A. David Thaeler, Pennay Farms	2nd Thurs	3	32
Collar	Eugene Linberg, Naples	Lloyd Caudill, Naples	1st Wed	1	94
Columbia	Jose Govanechaa, Laka City	D. D. Waifanbach, Laka City	3rd Wed	1	23
Dade	Charlas F. Tate Jr., Miami	Warran Lindau, Miami	1st Tues	268	2619
Desoto-Hardee-Glades	Ernaat P. Palmer, Weuchula	Adly Z. Sedaros, Wauchula	1st Tues	7	18
Dixie (See Taylor)					
Duval	Guy T. Salender, Jacksonville	Charles B. McIntosh, Jacksonville	1st Tues	85	703
Escambia	C. Fannar McConnell, Pensacola	Robert K. Wilson, Pensacola	2nd Tues	41	234
Flagler (See St. Johns)					
Franklin-Gulf	J. Wayne Handrix, Port St. Joe	W. T. Weatherington, Apalachicola	Last Wed	0	9
Gedden (See Penhandle)					
Gilchrist (See Alachua)					
Handry (See Palm Beach)					
Highlands	Glenn V. Hough, Sabring	H. Fraderrick Kaiber, Sabring	3rd Mon	0	46
Hillsborough	Thomas E. McKali, Tampa	Jeff W. Harris, Tampa	1st Tues	101	620
Holmas (See Panhandle)					
Indian River	James Copeland, Varo Beach	Ernaat Jackson, Vero Beach	3rd Tues	5	65
Jackson (See Penhandle)					
Jafferson (See Capital)					
Lake	H. Pratt Carter, Leesburg	Charles D. Anderson, Clermont	1st Wed	0	84
Lee	Larry Garratt, Fort Myers	Jeffray Lang, Fort Myers	3rd Mon	19	266
Leon (See Capital)					
Levy (See Marion)					
Liberty (See Panhandle)					
Madison	Julien M. DuRant, Madison	Earl Creech, Madison	1st Tues	0	6
Manatee	Robert King, Bradenton	Anthony Cuva, Bradenton	4th Tues	19	128
Marion	James L. Stone, Ocala	Charles E. Jordan, Ocala	3rd Tues	11	75
Marlin	F. F. Kreuskopf, Stuart	John W. Eckersley, Stuart	1st Thurs	6	62
Monroe	Barry Mankowitz, Key Colony Beach	Robert Carraway, Key West	3rd Thurs	2	56
Nassau	Ferid Ullieh, Fernandina Beach	Cecil B. Brewton, Fernandine Beach	3rd Thurs	3	17
Okaloosa	D. D. Arrowsmith, Fort Walton Beach	Dan Beraha, Fort Walton Beach	3rd Tues	7	56
Orange	James J. Schoeck, Orlando	Edward Ackman, Winter Park	3rd Wed	69	597
Osceola	Archie E. Tate, St. Cloud	Alonzo Logan, Kissimmee	3rd Tues	0	28
Palm Beach	Reginald Stambaugh, W. Palm Beach	Robert Gardner, W. Palm Beach	4th Mon	102	561
Penhandle	Glenn E. Pedgett, Merrianna	William F. Brunner, Marianne	1st Thurs	4	60
Pasco	Dwayne Dael, Dade City	Gragory Witters, Dade City	2nd Thurs	15	53
Pinellas	Donald G. Nikolaus, Dunadin	James M. Neill, St. Petersburg	1st Mon	133	648
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Sumtar (See Citrus-Hernando)					
Suwannee-Hamilton-Lafayette	Lao Klenk, Jasper	Frank Gaiger, Live Oak	3rd Mon	0	10
Taylor	John H. Parker Jr., Perry	John A. Dyal, Perry	Last Mon	0	13
Union (See Alachua)					
Volusia	Irwin Leidar, Daytona Beach	Frank J. Lili, Deytone Beach	2nd Tues	3	223
Wakulla (See Capital)					
Walton	L. L. McCormack, DeFunak Springs	E. H. Myers, DeFunak Springs	2nd Tues	0	5
Washington (See Penhandle)					
Total.....				1,287	10,063
Grand Total.....					11,350

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For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days

- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice

- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.



Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache,

peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older.

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

Her next attack of cystitis may require

the BactrimTM 3-system counterattack



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Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of

Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of intracolonic colonization by fecal uropathogens. It has no significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract

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HISTORICAL ISSUE

Medicine and the Cuban Physician

Enrique Huertas, M.D., Guest Editor

William M. Straight, M.D., Historical Editor

A character all its own.



Valium (diazepam) is a benzodiazepine with a character all its own.

Pharmacologically, it has been described as more potent mg-per-mg than other available anxiolytic benzodiazepines. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

Valium[®] (diazepam)^{IV}

2-mg, 5-mg, 10-mg scored tablets
a prudent choice in psychic
tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

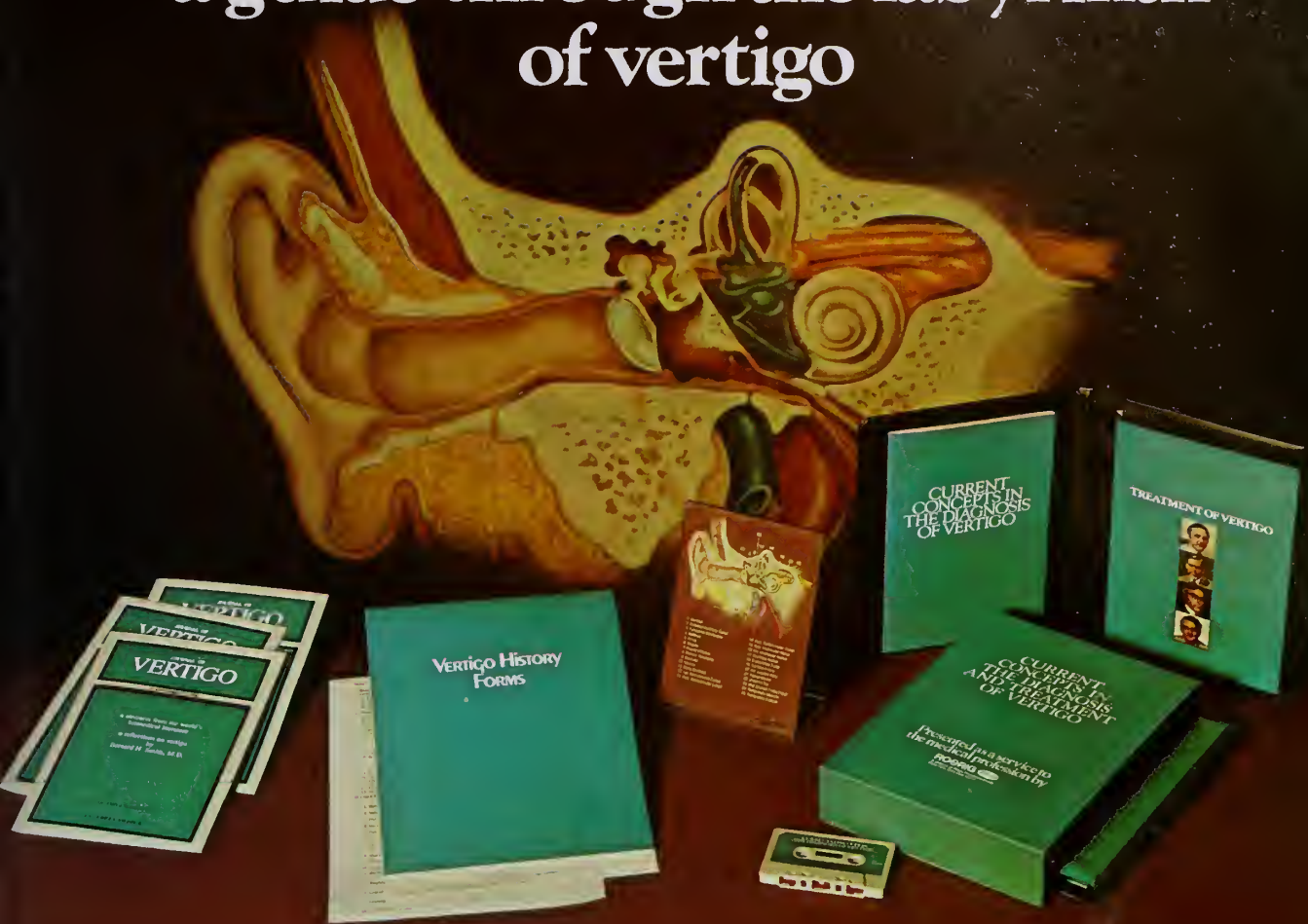
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Roerig presents a guide through the labyrinth of vertigo



Vertigo is a potentially complex condition often encountered in office practice. Over 3.5 million patient visits last year were traceable to conditions of the inner ear, with vertigo or dizziness as prominent symptoms.

Roerig can help keep you informed on the latest in vertigo therapy through complimentary materials designed to aid in diagnosis, treatment and patient education.

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■ **Continuing Update on Vertigo Therapy**—The most recent research and clinical concepts are presented in a semi-annual publication, *Journal of Vertigo*. Contents include an original article and abstracts from the international biomedical literature.

■ **Accurate Patient History-Taking**—A specially designed patient questionnaire can aid in determining the nature of your patients' symptomatology. The *Vertigo History Form* can also provide important diagnostic clues to possible etiologic factors.

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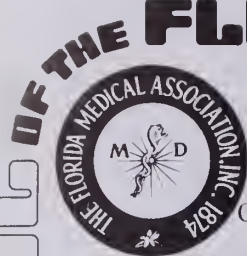
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This Issue

We are indebted to Dr. Enrique Huertas, Guest Editor of this issue and to Dr. William M. Straight, Historical Editor of The Journal for collaborating in bringing to fruition this issue on Medicine and the Cuban Physician. We are also most grateful to all the authors who contributed to this issue of The Journal. See contents on opposite page.

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AUGUST COVER—The seals of the University of Havana School of Medicine and the Cuban Medical Association in Exile are displayed on this month's cover to highlight this special issue of Medicine and the Cuban Physician.

Special Issue

Medicine and the Cuban Physician

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Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

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Intravenous administration should not be given because of increased likelihood of side effects.

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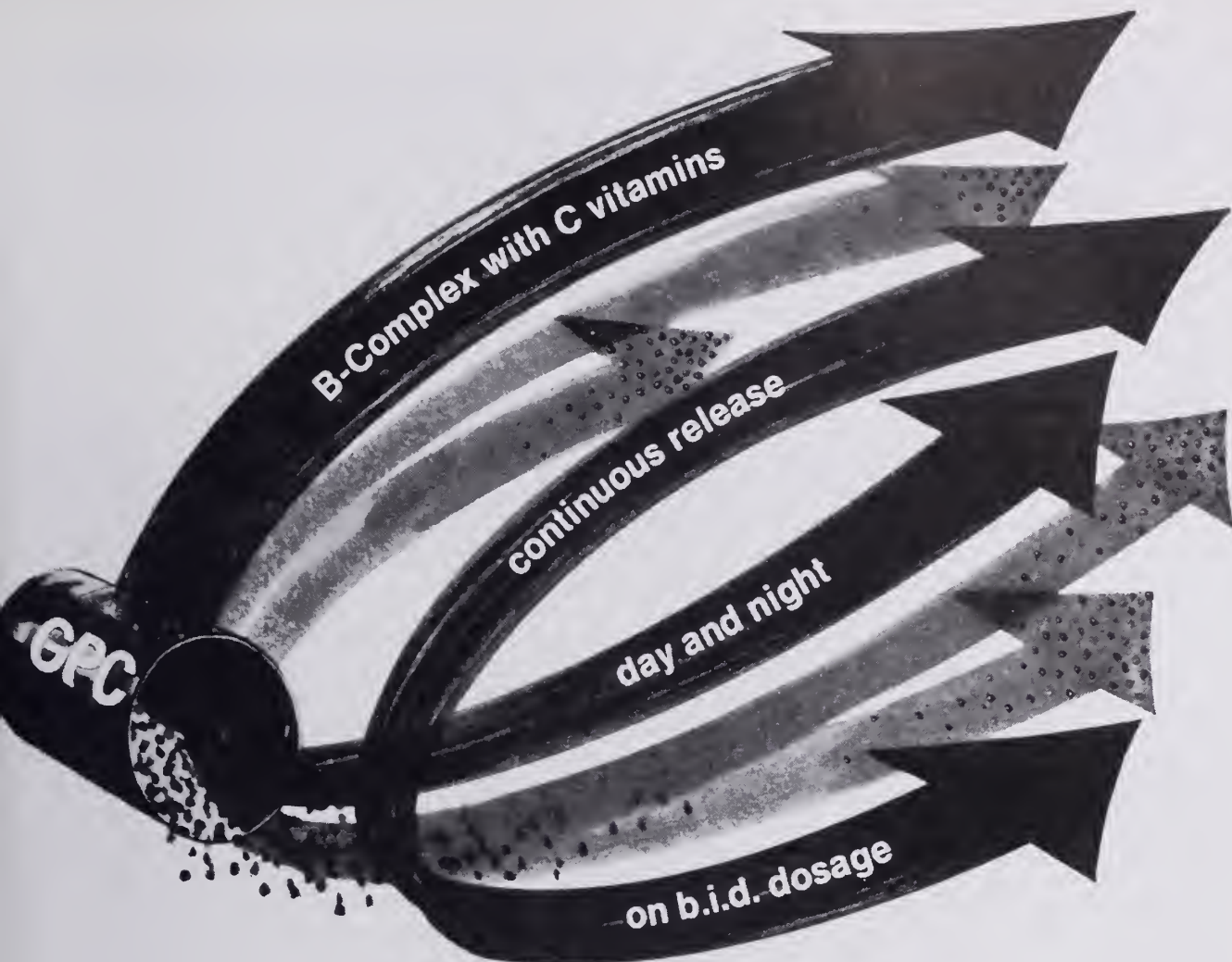
Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

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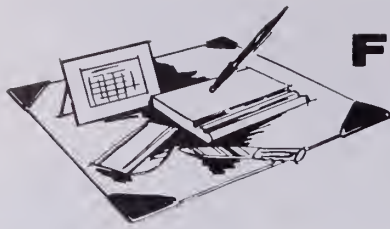
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FROM THE EDITOR'S DESK

CONFRONTATION

HEW Secretary Joseph Califano has charged that the nation's health care system is a "very costly . . . virtually noncompetitive . . . obese business that needs profound reform." Among other charges made at the recent AMA Convention in San Francisco, Califano maintained that a migration of doctors to the suburbs has forced city dwellers to patronize hospital outpatient departments at higher costs. He described health insurance as an inequitable "crazy quilt" with 18 million persons completely uncovered. In rebuttal, AMA Executive Vice President James H. Sammons said the Carter Administration is big on talk but "short on substance." Dr. Sammons agreed that doctors need to help control costs, but "when cost becomes the overriding factor in medical decisions, first you get rationing of care to patients," next second-rate medical equipment, next a pinch on physician training "and finally you wake up one day to find you have a second-rate medical system."

* * * *

REPRESENTATION

"Representation" is what young AMA members want most from their national Association, according to a survey conducted by the AMA's Ad Hoc Committee on Services to Young Physicians. Non-members were included in the survey and they said they wanted the same thing.

* * * *

VIDEO CLINIC

AMA will begin distributing this fall a new video tape continuing medical education series. Called CME Video Clinics, the package includes a program on color tape (for use on a U-Mataic $\frac{3}{4}$ inch tape player, syllabus, tests and instructions). The

programs will be available to hospitals and physicians for a nominal charge. They meet the criteria for AMA Category I CME credit.

* * * *

AMA SCIENTIFIC MEETING

AMA's mid-winter business and scientific meetings will be held separately this year. The 30th and final Clinical Meeting, including both meetings, was held in Philadelphia last December. This year, the House of Delegates will meet in Chicago December 4-7. The AMA Winter Scientific Meeting will be in Miami Beach, December 10-13. The scientific program was arranged by a Florida committee headed by FMA Vice President J. Lee Dockery, M.D., of Gainesville, and Yank D. Coble, Jr., M.D., of Jacksonville, Chairman of the Council on Scientific Activities.

* * * *

JAIL CONFERENCE

A National Jail Conference will be sponsored by the AMA in Milwaukee, August 21-22. M. Roland Nachman, Chairman of the Human Rights Commission on the Alabama Prison System, will give the keynote address on "The Role of the Court in Upgrading Medical Care and Health Services in Jails."

* * * *

TRANSFER

The Department of HEW now has available applications for U.S. citizens studying in foreign medical schools who wish to transfer to U.S. schools. The Health Professions Education Assistance Act of 1976 requires U.S. schools

receiving federal capitation to reserve an "equitable number" of advanced standing positions in their classes for such students. Among the requirements for transfer is passage of Part I of the National Board of Medical Examiners' examination. HEW estimates 6,000 U.S. citizens are studying medicine abroad.

* * * *

FTC

A move to extend the jurisdiction of the Federal Trade Commission to include non-profit associations has failed. The House Commerce Committee voted to continue the exemption of such groups. The Senate Commerce Committee deleted the provision from its version of the bill.

* * * *

HOSPITAL REVENUE CAP

The Administration's proposal to limit inpatient revenues of most hospitals to nine per cent a year appears to have lost ground. Health care providers were almost solidly opposed in three days of congressional hearings. Testimony from the AFL-CIO and United Auto Workers was only luke-warm. AMA witnesses compared the plan with the economic stabilization program of a few years ago which had kept controls on the health care field while removing them from the rest of the economy.

* * * *

PHYSICIAN DISMISSAL

AMA has asked the New York State Supreme Court for permission to file a brief in a case involving the dismissal of a physician from a hospital. The plaintiff was fired by Metropolitan Hospital Center without a hearing. The hospital contends it does not need to grant a hearing because the doctor was an employee of a medical school, not of the hospital. The school will not give a hearing because it contends it did not fire him. AMA said its brief would support the principle of due process.

* * * *

LAETRILE

Federal authorities have outlined conditions for the importation of the controversial anti-cancer substance, laetrile. A federal judge in Oklahoma

City issued an order stating that a patient wanting to import the substance from Mexico will be required to present an affidavit signed by a U.S.-licensed physician that he is terminally ill.

* * * *

NHI

The Administration's program for national health insurance reportedly will be submitted to Congress next year. HEW Secretary Joseph Califano said the program will be universal and mandatory, phased in over several years, and with a special commitment to preventive care, especially for children.

* * * *

PSRO

AMA has told the Department of HEW that every effort should be made to use physician-based organizations for administration of the Professional Standards Review Organization program. HEW also was asked to extend by one year, or to January 1, 1979, the date on which it can begin designating "alternate organizations" composed of non-physicians.

* * * *

POSTAGE DUE

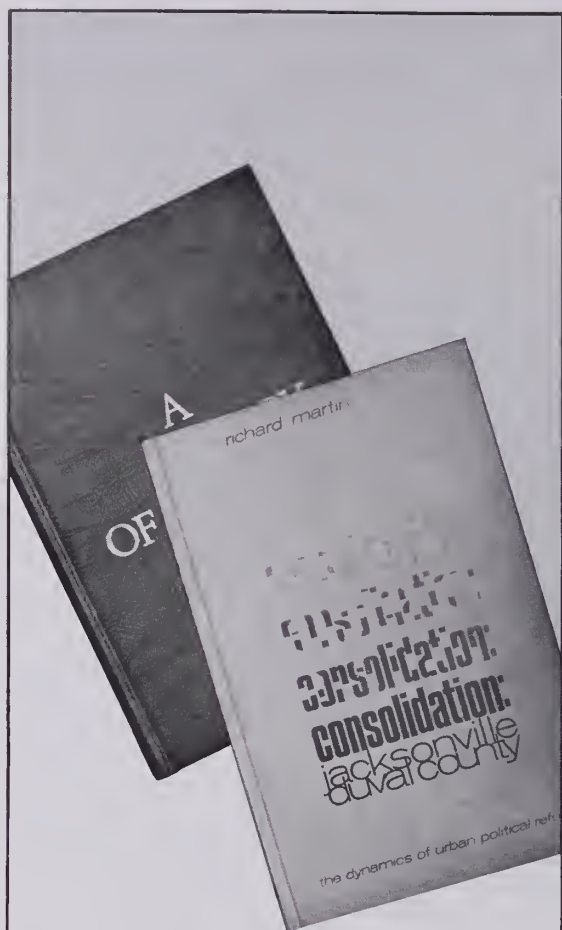
The American Medical Association says it has been conducting a "technical review" of a U.S. Postal Service claim that it owes about \$1 million in back postage. In a telegram to state medical associations, AMA stressed that it had voluntarily informed the postal service that it had not properly filled out forms used in mailing publications at the second class rate. "The postal rate error was innocent," AMA said. "There was no intent to deceive or defraud."

* * * *

AMA-ERF

AMA members have been sent a solicitation for contributions to the AMA Education and Research Foundation student loan guarantee program. Each dollar contributed provides \$12.50 in loans from a participating bank to medical students and physicians-in-training.

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S. pneumoniae (*D. pneumoniae*)—Upper and lower respiratory tract infections of mild to moderate degree.

M. pneumoniae—For respiratory infections due to this organism.

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Entamoeba histolytica—In the treatment of intestinal amebiasis.

L. monocytogenes—Infections due to this organism.

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Contraindications:

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Warnings:

Safety for use in pregnancy has not been established.

Precautions:

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Adverse Reactions:

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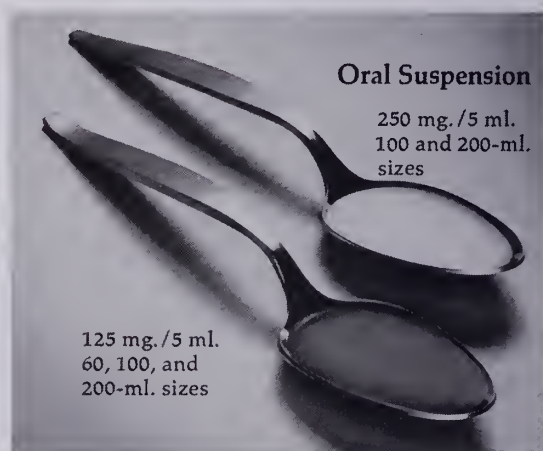
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SPECIAL ISSUE

MEDICINE AND THE CUBAN PHYSICIAN

Enrique Huertas, M.D.

Guest Editor

INTRODUCTION

One of the responsibilities of the would-be historian is to recognize current events of historical importance and record these for future generations. One of the most significant such events in Florida history during our lifetime has been the influx of Cuban refugees from all walks of life.

Since the rise to power of the Marxist-Leninist Fidel Castro on January 1, 1959, more than 650,000 Cubans have fled to the shores of the United States. As the Cuban physicians were among the most energetic and outspoken in opposition to the Communist takeover, many of the leaders of the profession were forced to flee their homeland or face imprisonment and death. Over a thousand of these Cuban physicians have settled in our state, learned our language, obtained citizenship, passed the required examinations, joined our county and state medical societies and work alongside the native-born physicians in the daily care of the sick. Still others are engaged in doing research and teaching in our medical schools.

More than a year ago your historical editor, feeling that the story of these physicians should be recorded, obtained approval of the editorial board of this journal to proceed with such a project. He approached Dr. Enrique Huertas, the energetic president of the Cuban Medical Association in Exile, who agreed to serve as guest editor.

Dr. Huertas asked the collaboration of a small group of Cuban physicians, each an authority in his field, planned this issue of the J.F.M.A. and brought it to fruition. In its pages the reader will find accounts of Cuban medical history (the only such available in English) before the advent of Castro, an account of the forceful Communist takeover of the Cuban Medical Association, stories of the hardships and privations of our Cuban medical colleagues, the story of the Cuban Medical Association in Exile, and a view of health care in Cuba today as recounted by a physician who came from Cuba very recently.

William M. Straight, M.D.
Historical Editor

FOREWORD

Several months ago, our distinguished colleague and friend, William M. Straight, M.D., Historical Editor of the Journal of the Florida Medical Association, wrote to us requesting that we prepare an article for publication in the August, 1977, issue of the Journal of the Florida Medical Association on the Cuban physician migration to this country, bearing in mind the importance of this historical event for the benefit of future generations of physicians and medical historians throughout the world. Dr. Straight and I had a lengthy conversation concerning the subject matter, length, illustrations and other important details about the project. After much thought and after consultations with many colleagues, I accepted the difficult and delicate task with the purpose of humbly rendering a service to my country, Cuba, and to the Cuban medical profession, which I represent as president of the Cuban Medical Association in Exile.

We have worked very hard and for many hours to comply with this request which so honors us and to prepare the material for the chapter we wrote ourselves, and it seemed appropriate to us, in order to present the best possible manuscript, to solicit the valued collaboration of the following prestigious and distinguished exiled Cuban physicians who have special knowledge of the different areas into which the work was divided and who were able to meet the deadline for the material in English: Jorge

Beato, M.D., Virgilio Beato, M.D., Juan C. Bolivar, M.D., Eduardo Borrell Navarro, M.D., Rafael Calvo Fonseca, M.D., Frank Canosa, M.D., Agustin W. Castellanos, M.D., Gilberto R. Cepero, M.D., Augusto Fernandez-Conde, M.D., Jose C. Gros, M.D., Jose J. Iglesias, M.D., Fernando R. Milanes, M.D., Reinaldo Muniz-Cano, M.D., Julio Ortiz Perez, M.D., Rafael A. Penalver, M.D., Eliseo Perez-Stable, M.D., and Guarino Radillo Garcia, M.D. When this work is published in Spanish, all the chapters that were not ready in English will appear in full. Finally, out of the joint effort of all of us, we have put together this issue which has emerged as a concise study and brief review of the history of medicine in Cuba from colonial times until now, including, of course, the period of exile.

Our thanks to Dr. Straight for the distinction he has bestowed on us by selecting us for this task that will, for many reasons, be a historical record that will serve from now on as a true and official guide concerning medicine and the Cuban physician.

Our thanks to all of our distinguished Cuban colleagues who have contributed so magnificently to this work.

Our appreciation and our gratitude are also extended to the editorial and administrative staff of the Journal of the Florida Medical Association.

Enrique Huertas, M.D.
Guest Editor

DEDICATION

To all of our former professors who taught and guided us with dedication and wisdom during our student days at the University of Havana's School of Medicine.

Havana Faculty of Medicine in Exile

Foundation and First Activities (1960-1964)

Fernando Milanes, M.D., F.A.C.P.



Dr. Milanes

Our arrival from Havana, Cuba on October 8, 1960, brings to my mind sad remembrances, a real nightmare, leaving behind an entire life devoted to improve the medicine of our country, as well as a dream of a better democratic Cuba.

All dreams of human rights and freedom were

destroyed by International Communism and the monstrous and cynical surrender to Russia of the sovereignty of our beautiful island by Fidel Castro.

Requested by a group of American colleagues, I had the opportunity to publish in the Bulletin of the American College of Physicians, of which association I was a fellow, an article entitled, "Why I Left Cuba."

As soon as I arrived in Miami, traveling to Chile to a gastroenterological congress, I had a telephone call from my close friend and faculty colleague, Dr. Jose Centurion, in order to discuss our possible stay in the U.S.A. The memory of Dr. Centurion is something sacred to me as a capable, honest, patriot and extraordinary medical man.

We both could mitigate our anguish upon the hopeful and happy encounter with Dr. Ralph Jones, Jr., at that time the chairman of medicine of the University of Miami. We met a man full of good will and strong drive, ready to solve our problems with the prompt organization of the Faculty of Medicine in Exile.

Simultaneously, we had the agreeable visit of Dr. Henry L. Bockus from Philadelphia, a close friend of ours, who was also willing to help in our endeavor here in Miami. He thought however, that Ralph Jones had a better position and resources in Miami to accomplish the hard task of the organization of a center for medical teaching and for seeking jobs for the Cubans. Dr. Bockus later orga-

nized with CARE a scientific trip to South America, which made possible the convincing anticommunist campaign which was achieved by a group of us: Drs. Agustin Castellanos, Manuel Viamonte, Jr., Francisco Barrera, Antonio Rodriguez Diaz, and myself.

Following Dr. Jones suggestion we created the Havana Faculty of Medicine in Exile with: Dr. Jose Centurion, Dr. Fernando Milanes, Dr. Vincente Pardo Castello, Dr. Jose Lastra, and Dr. Hector Rocamora. Sometime later we had also Dr. Angel Vieta, ex-dean of the Havana School of Medicine and Dr. Rafael Penalver.

The exodus from Cuba was increasing day by day and among the M.D.'s we counted a high percentage of the 140 professors who made up the faculty of medicine in Havana, Cuba. About 50 of those remained in Miami and the committee above mentioned, maintained contact with them for advice and consultation.

Also, we must mention a small group of young professors who were relocated in different places of the U.S.A. who have come back to Miami, being at present distinguished members of our teaching hospitals in Miami connected with the university medical school. Dr. Eliseo Perez Stable today is the Chief of Medical Department of the V.A. Hospital, Dr. Manuel Viamonte, Jr., Professor of Radiology and others.

Our Faculty in Exile also had since the beginning, the full support of the past-dean of the School of Medicine of Miami, Dr. H. C. Nicholson, and the efficient cooperation of most of the American professors who fulfilled satisfactorily the task of teaching. Their lectures, tests, etc., related to the Educational Council for Foreign Medical Graduates (E.C.F.M.G.) programs were a success, preparing the first group of Cuban doctors who attended the first examination (E.C.F.M.G.) in March, 1961. We, the Cuban professors collaborated, covering the difficult job of modest teachers and eager students.

The first grade returns were poor, because as expected, a good percentage of the physician-students did not pass, among them even some of the professors. The multiple choice examination plus

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the language barrier came out as obvious negative factors. At the same time also the frustrated Bay of Pigs Invasion of Cuba was in the preparation stage and my own son, today a Miami psychiatrist, was in Guatemala as one of the brigade members. Thus, our psychic condition was very poor. Most of us suffered an evident anxiety-depression syndrome.

Several courses followed this one with marked improvement in results and the reader may refer to Dr. Rafael Penalver's article for detailed information on the subsequent activities of the Cuban-American educational programs achieved here in Miami.

A short time after our first period of work, we had the shocking news one morning of Dr. Ralph Jones illness, which compelled him to resign his position in the school of medicine. We lost unfortunately our friend, protector, mentor and the soul of the organization. His work with us passed to his assistant, Emil P. Taxay who some time later for obvious reasons also abandoned his school position and his connection with our organization. Large groups of Cubans continue to pass the examinations of the E.C.F.M.G. twice a year, and the program has changed its name to the present International Medical Center. Its activities extend to physicians coming from many Latin American and other overseas countries, and are directed by our capable friend, Dr. Rafael Penalver.

Some of us continued as professors, and I had the opportunity of completing 24 courses, giving mainly lectures on gastroenterology. This meant to me retirement at the end of the year 1972 as a teacher, after 42 consecutive years of continuous work in medical education; 30 in Havana, and 12 in this beautiful Miami with the warm hospitality of the University of Miami School of Medicine.

Drs. Jose Centurion and Angel Vieta, both of long and reputed professorship in Havana, were responsible for giving medical credentials to the thousands of Cuban colleagues who arrived from Cuba without proper medical identification documents. Every Cuban doctor, now working in this country, must be grateful, upon remembering the kindness and exhausting work these two men performed at the end of their fragile lives. Death in exile was a frequent happening, even after completing the examinations. We must give posthumous homage to every one of them, particularly to the founders of the first faculty committee: Drs. Vincente Pardo Castello, Angel Vieta, Jose Centurion and recently Dr. Jose Lastra.

In October, 1960, also we met here Dr. Enrique Huertas, founder and still president of the Cuban Medical Association in Exile. The Faculty of Medicine cooperated warmly with him, some of us belonging to the executive committee. Dr. Huertas is presenting in this F.M.A. issue a detailed history of the association, a powerful organization which has cordial relations with the Dade County Medical Association and the Florida Medical Association. Dr. Huertas has shown an extraordinary skillfulness, crowning the association with success.

I do believe it very important to write a short narration of my connection with the Veterans Hospital, then located in Coral Gables, during the years 1960 to 1964. This served as liaison between the headquarters of the Veterans Administration in Washington and our Faculty of Medicine in Exile. This facilitated the relocation of Cuban doctors in the different V.A. Hospitals all over the country. Several hundred doctors thus obtained wonderful jobs after passing the E.C.F.M.G. This task was accomplished with the cooperation of Earl G. Gluckman as director and particularly Dr. Edward C. White the chief of staff. Dr. White was very fond of the Cubans and, by the way, he witnessed sometimes the clandestine arrival of refugees on board fragile boats while he was fishing in Biscayne Bay during his weekends.

At the V.A. Hospital I was assigned to the Section of Gastroenterology in charge of Dr. Martin H. Kalser in the Department of Medicine directed by Dr. Fred Wassermann. I collaborated with these kind gentlemen to the best of my abilities as instructor of residents in G.I. and also in the teaching of second year medical students. I covered some of the aspects of physical diagnosis, particularly in abdominal semiology.

Finally, we modestly projected in 1963 the issue of a book on medicine in Cuba before and after Castro-Communism. This was the suggestion of Emil P. Taxay who showed skill and hard working qualities, and dreamed of the organization of a Latin American medical center, in the fabulous geographical location of Miami. The book was supposed to contain information regarding: our school of medicine in Havana, our hospitals, practice in Cuba, research activities, etc., plus the achievement of the Cuban doctors in exile. At that time we had some figures comparing our medical achievements in Cuba with those of the other Latin American countries. These were published by the Pan-American Union and the American Statistics Institute, both in Washington, D.C. in 1958. They showed as the

main data: the existence in Cuba of 84 (Cuba had 1200 sq. kms. and 6 million people then) hospitals with a proportion of 2.6 beds per 1,000 inhabitants and 6,300 M.D.'s of which 2,500 worked in our Social Security Private Hospitals.

The members of the faculty were getting older and tired and the project was never completed although it was planned and indexed and some chapters written.

Now, fourteen years later a special issue of the Florida Medical Association journal devoted to Cuban medicine in Florida has been suggested to

our energetic Dr. Enrique Huertas. We consider it as a wonderful document showing the effort of Cubans and Americans in good will and understanding. Despite my semi-retiring status I could not refuse to cooperate modestly in this project and also to take advantage of this opportunity to express our gratitude and great appreciation to the University of Miami School of Medicine, their professors, the American colleagues and every one of the American medical organizations which have helped us, the Cubans in exile, to pursue our medical careers in this great free country.

The Cuban Physician in Exile and the Cuban Medical Association in Exile

Preamble



Dr. Huertas

Enrique Huertas, M.D.

The Cuban physician has his basic roots in the most classical European tradition and with time and geographic proximity, he has received the influence and modification of the style and technology of American medicine. His basic preparation is theoretical and his orientation and training is pre-

dominantly clinical. Traditionally, the Cuban doctor enjoyed a prevailing influence in the society of our country along with an elevated social status. And these features contribute to explain his conduct and aspects of his character. The Cuban doctor was received like a friend or a relative in every home, as someone in whom the family placed a full and special confidence. On his part, the doctor, with his equitable, merciful and fundamentally human conduct, conquered the sympathy, the affection and the respect of society at all levels.

A considerable proportion of doctors in Cuba

were from the middle and poor classes of the country. That is, men and women, white and black, who became doctors as a result of great and tenacious individual and family efforts. Through will, study and deprivations they arrived at the superior position accorded them by everyone in the country. The Cuban doctor was always considered, and exile has served to confirm this, as a well-prepared and well-qualified professional. When we graduated from our bicentenary University of Havana, the dearest wishes, dreams and hopes seemed waiting for us after the long road traveled. We felt that a time of roses was now coming for the physician.

But we forgot that roses bear thorns and how far were we from imagining the additional price our lives had to pay in order to live decently and deserve the respect of our own and of strangers. We didn't know that we had to be an example and that we had to pay through great effort and sacrifice to join our people in the writing of this painful and tragic page in the history of Cuba.

The Cuban Doctor's Journey Into Exile

Around 3,500 Cuban physicians have abandoned the island since Castro took power out of the approximately 6,300 doctors in Cuba at that time. They, like the immense majority of the Cuban

Dr. Huertas is President of the Cuban Medical Association in Exile and President of the International Cuban Medical Association Congress.

people were taken by surprise it might be said when Castro imposed a Communist dictatorship on Cuba's nearly seven million inhabitants through force and deceit. One million Cuban people are living in exile throughout the world. More than 80% of the physicians in Cuba today would leave the country immediately if the authorities would permit it. The evil intent with which Castro had traced and devised his plan was unveiled for all of the people of Cuba on December 2, 1961, when Castro himself declared in his speech: "I say it here with entire satisfaction and with complete confidence: I am a Marxist-Leninist and I will be a Marxist-Leninist until the last day of my life . . ." and immediately after that, he confessed: "I have hidden it until now because I knew that if it had been known in time, the people wouldn't have followed me."

Many doctors had to accelerate their departure from Cuba because of political persecution. Others, less fortunate, died for their active resistance to the tyranny. A great number of them suffered imprisonment and, as far as we know, more than fifty physicians are still in political prisons. The physicians who left the island left everything behind, offices, libraries, properties and material and spiritual goods. The regime obliged them to comply with an itinerary of penance and punishment for several years before granting them permission to leave the country. Many died in that anguished wait.

The First Years of Exile

Upon arriving in exile, the Cuban doctor had to practically begin his career anew. At first, the possibility of a speedy return to our country oriented the doctor towards intense activity in the field of the patriotic fight and into accepting jobs of a more or less temporary nature that were many times unrelated to their profession. Thus, we had physicians working as technicians in hospitals, as aids in operating rooms and even as chauffeurs, elevator operators, stewards, dry cleaners and tomato pickers, etc., etc. The economic situation of the doctor during these first years was extremely limited and on occasion, quite precarious. Later, the course of events and a series of facts such as the results of the Bay of Pigs invasion and the unfortunate Kennedy-Khrushchev pact that jeopardized the cause of Cuba's freedom following the missile crisis of October, 1962, obliged the Cuban physician to modify his thinking and job plans to focus on the convenience and the necessity of directing his activities towards the security offered within his own profession.

The Life of the Exiled Doctor After the First Years

Faced with the reality of the Cuban situation, the increasing cost of the needs of their families and the education of their children, the doctor, in a great majority, decided to orient his steps to ways that would facilitate a better adaptation to the North American system of medicine, paving a way to better job possibilities and a higher income. He had to graduate as a doctor again. It was then that the physicians decided to begin their training in hospitals and in their specialties in the United States and to study for the ECFMG, the State Board Examinations, the revalidations of their titles in the countries where they lived and, later on, the boards of their specializations. Many are the Cuban doctors who have achieved fame and money in the United States and other countries and all in general have gained prestige and recognition because of their work and their conduct. Others have dedicated the best of their lives and efforts to the cause of Cuba's freedom. The love of Cuba persists in all the Cuban medical class and the desire for the freedom of our native land remains alive and strong.

Different Systems: Problems of Adjustment

The homes of the Cuban doctors, like the homes of all Cuban refugees, have passed and are passing through special situations. The Cuban mothers and fathers reached the lands of exile with a basic formation, customs and traditions that were well-defined and rooted and they have naturally wanted to transfer the same or similar patterns to their children.

Obviously, this turns out to be a difficult thing to do because of the environment surrounds the youngsters, the language barrier and modern life and customs that differ from the parental influence. Yet, in spite of everything, the Cuban homes in exile have managed to maintain their children within customs, traditions and concepts of life that show the extraordinary value that fatherland, family and God have for a person and his destiny.

The Exiled Cuban Doctor

Let us begin stating that the exiled Cuban doctor, like the democratic Cuban in general, is a symbol of freedom wherever he or she lives and wherever he or she works. Medicine is studied, at least in our countries, principally because of a profound vocation, of an irresistible tendency towards service and help to his fellow men. None suffered perhaps as much as the physician the deepest pain of having to abandon his country and

his work, and, in many instances, his family. The fact is that with his stethoscope, the doctor picked up the people's rebellion against the intent to communize the country in each Cuban home, from the first whispers when the first symptoms appeared. The Cuban physician did not abandon his patients. The Cuban physician marched into exile with his people.

To the Cuban physician, adversity has served as a new lesson in the itinerary of our lives. We have learned to place a better value on what we had and to have a full awareness of the reality of our time.

At a time when few are concerned with principles, we know the value of defending them and we know that in doing so we are helping to preserve a better destiny for our sons and daughters.

The pain and reality of exile have served to confirm to all of us the difference between material goods which are always transitory in nature and the moral and ethical principles that, with dignity and honor, are always of a permanent nature. The triumphs of the exiled Cuban doctors, like the triumphs of all of the Cubans in exile, be they in the factories, in industry, commerce, business, education or the professions, has been noteworthy and has deserved words of praise in the most important newspapers and magazines of the United States and the world. Mention need only be made of the article which appeared in the magazine *Business World* in May of 1971, which pointed out that the Cuban exiles were a foreign group of the highest quality and that they had progressed more in the least amount of time than any group in the history of the United States, a country of immigrants. An article with similar opinions was published in the *AMA News* in the summer of that same year. The Cuban physician maintains the best relations with the North American counterpart and with physicians in general in the countries where he lives and works and has been generally very well received everywhere. He has felt warmth and affection to mitigate his pain and his absence from his native land and he has been offered job opportunities to redirect his life and orient his family while his pilgrimage lasts. That is why it is always a concern of ours to express with all sincerity our gratitude to the colleagues in North America and Latin America and all colleagues in countries where there are exiled Cuban doctors as well as to the peoples, medical institutions, universities and governments that have taken our people in from their exile with sympathy and respect.

A Brief History of the Founding and a Review of the Cuban Medical Association in Exile and Its Professional, Scientific, and Patriotic Activities

The Cuban Medical Association in Exile (CMA) was founded in Miami, Florida, in October of 1960, by 87 exiled Cuban doctors. Today it includes 3,070 members, joined in a powerful union of patriotic, scientific and professional strength that has made possible the great work undertaken and the recognition, prestige and respect attained by one of the oldest and most respectable institutions of the Cuban exile.

In the institution's founding document, we said that on such a singular occasion we denounced, before the conscience of both the American continent and the world, the drama and the tragedy of a Cuba enslaved by an oppressive totalitarian system that was implanted in our country by force, terror and deceit. We pointed out that when this historical process was viewed from the perspective of time, it would be seen by posterity as an amazing example of political perfidy and we emphasized that today when we say Judas, it is understood that we are speaking of someone who has sold out his friend. Tomorrow and forever, we will say Fidel Castro and with just saying it, it will be understood to refer to someone who has sold out his country and his people. We also expressed at that time that there was no longer any education or culture in Cuba that was not directed by the state and its interests. There weren't any universities that weren't the universities and schools of medicine directed by the state with political ends. That there were no free professional unions nor any independent medical class. That it had become extremely difficult to practice the profession of medicine with dignity and ethics and that the private practice of medicine was on the road to disappearing.

Unfortunately, all of those things have proven true and many more. Our people have suffered for years a terrible crucifixion. Under those conditions, the practice of medicine in our country has lost its motivation and the attention of the people's health has suffered serious breaks and radical transformations. The new medical promotions with sectarian, inadequate and arbitrary study plans, have fed on students selected for their affinity and militancy with Cuba's sole party, the Communist party organized under the directives set forth by the Soviet Union, and not for their level of preparation or their vocation for a career in medicine.

It becomes extremely difficult to form an integrated opinion of the dislocation of education in Cuba at all levels and in all orders of national life because the propaganda and indoctrination campaigns mold everything to the convenience of the government, cover up the truth and present lies as if they were axiomatic. In the fact of the situation described the founding of the Cuban Medical Association in Exile was fully justified and time has confirmed it as it has confirmed the attitude assumed by the Cuban medical class, marching off in such appreciable numbers into exile in search of liberty and a better and more dignified destiny for their families and with the natural desire to keep up with their profession, in order to better serve the sick in the demanding and necessary field of medical excellence.

The CMA was founded basically to help and serve the doctor in whatever could be useful, lawful, decorous and ethical to aid in the care of the health of our compatriots, of the people of the United States and of the peoples of Latin America and the world that welcomed us in our journey as exiles, to maintain the highest standard of scientific achievement in the Cuban doctors and in fulfillment of their patriotic and inescapable duty in the struggle for the liberty of Cuba.

The fundamental goals of the Cuban Medical Association in Exile have been and are: to promote science, education, culture, research, the art of medicine and the most complete health care attention for the citizen and the sick and to proclaim the exaltation of human values and the fundamental rights of man. In the same way, it has dedicated itself with the noblest of human passion to promoting the broadest spirit of brotherhood amongst all such institutions throughout the world. Like other democratic institutions, it holds elections regularly, according to its regulations and statutes and its Executive Committee with 15 members is elected by direct vote amongst the doctors belonging to the association. The CMA has its antecedents in our country first in the Cuban Medical Federation (Federacion Medica de Cuba) and later in the Cuban National Medical Association (Colegio Medico Nacional de Cuba). In its trajectory it has concerned itself with maintaining the customs and traditions of the mentioned institutions and of the American Medical Association (AMA), the World Medical Association (WMA) and the national medical organizations of the democratic countries.

The Cuban Medical Association in Exile was granted the official recognition of the AMA in August

of 1961, and is further recognized by the different medical associations of the countries of Latin America and by the continental and world-wide medical organizations. It is also recognized by the most distinguished university centers and schools of medicine of the United States and the western hemisphere, by the cultural and educational institutions and research centers, and equally by the governments and official entities.

Perhaps one of the most important achievements of the institution is that the documents issued by the CMA are officially accepted everywhere and on every occasion, serving even as titles or university diplomas for those doctors who were unable to retrieve theirs from Cuba due to the political situation reigning in our country. This invaluable service to the doctor has been made possible through the strict system for checking the veracity of the applicant's status as a doctor that was established from the very beginnings of the association. The CMA also obtained the official recognition of the American Hospital Association in 1961 and because of this relationship, it has been able to offer, since its founding, lists of medical job openings that total around five thousand. In the patriotic field, the activity of the CMA has been unceasing. It has been present in all serious efforts towards the liberation of Cuba and has organized numerous memorable and historical events during the Cuban exile.

In the medical congresses in which Cuban doctors participate, they have always taken the opportunity to offer talks and conferences on the situation in Cuba and on the Cuban people's struggle for their freedom. We feel that to be a good doctor, one must also be a good citizen.

The Cuban doctor has ever been present in the battles for Cuban independence as shown in the history of our country. They were also present in the Bay of Pigs invasion. By the same token, they will be present on whatever similar occasions may arise. There hasn't been a rostrum in America and the United States or in the medical organizations of the hemisphere that has not heard, from the lips of the directors of the CMA or from some exiled Cuban physician, a documented exposition of the Cuban situation.

The records of the CMA are, in sum, the best witnesses of the scientific, professional and patriotic conduct of the institution and of its innumerable services to the medical profession at the times it has most needed them. They bear witness also to its concern that the exile maintain always the

highest level of conduct according to the virtues of our people and to its solidarity and identification and activities on behalf of the numerous medical colleagues suffering political imprisonment in Cuba and in general of all of the medical colleagues who maintain a worthy attitude in our country.

Equally, we commemorate each year the 3rd day of December as Cuban Physician Day, the anniversary of the birth of the wise Cuban doctor, Carlos J. Finlay, discoverer of the transmitting agent of yellow fever. This commemoration, as it was in Cuba, has become the most solemn and well-attended event of the Cuban medical profession in exile.

The CMA was favored and supported the reorganization of the Cuban specialists societies along the lines of the previous societies maintained by these professionals in Cuba. Presently, the following societies are quite active and are commendably fulfilling their scientific duties: The Cuban Ophthalmological Society in Exile, the Cuban Society of Obstetrics and Gynecology in Exile, the Cuban Society of Surgery in Exile, the Cuban Society of Otolaryngology in Exile, and the Cuban Society of Dermatology in Exile.

From the beginning, the CMA has lent its support to whatever might be of benefit in the development and research of medicine and offered from the first moments its spirit of cooperation and backing to the University of Miami and its Office of International Medical Education in its courses for the ECFMG.

Equally, the CMA has cooperated with the government of the United States, the State of Florida, Dade County, the Health, Education and Welfare Department (HEW), and the Cuban Refugee Emergency Center in everything concerning the solution of the problems of the Cuban physicians and the Cuban people.

The Cuban Medical Association in Exile's record from its founding in 1960 to the present time, along with the respectability attained is perhaps the most eloquent reason for the honor of having been asked to prepare this article, which we have put together with the greatest of care for the present and for the future.

The Presence of the Cuban Medical Association on the International Scene

The battle of the Cuban Medical Association in the International organizations has not been easy. It began in 1961 in Rio de Janeiro, Brazil, on the occasion of the celebration of the General Assembly

of the World Medical Association there. Later, uninterruptedly, that is, in Chicago, New York, London, Chile, Germany, etc., in each Annual Assembly of the WMA and in each meeting of the Governing Council of the WMA, we presented an exposition of the Cuban case and of the problems that concerned the Cuban doctor and his representative institution, the Cuban Medical Association in Exile, documenting our presentations with the most ample proofs. These presentations are on file in the offices of the CMA and the WMA.

At its 17th General Assembly held in New York in October in 1963, the WMA designated a commission made up of three prestigious members of that institution to study the accusations presented by the CMA in relation to the Cuban situation. The designated colleagues were Hector Rodriguez H., M.D., from Chile, Ernst Fromm, M.D., from Germany, and Edward R. Annis, M.D., from the United States. On the occasion of the 53rd Session of the Council of the WMA, the commission presented a broad and serious report dated April, 1965, which concluded that the charges formulated before the Assembly of the WMA by the Cuban doctors in exile through the CMA were true and that the Cuban National Medical Association (in Cuba) had, by its conduct, placed itself quite frankly at the margins and had violated the statutory dispositions not only of the Pan-American Medical Confederation but also of the WMA. This report led to Communist Cuba's medical delegation separation from international medical organizations, in all justice, a noteworthy triumph for the CMA.

The CMA has maintained the most cordial relations with the WMA and recently, in October of 1976, in Sao Paulo, Brazil, on the occasion of the WMA's General Assembly for that year, Enrique Huertas, M.D., President of the CMA was elected as Delegate of the General Assembly of the Associate members belonging to the WMA and he had the opportunity to speak once again before the Assembly, as he had done in Rio de Janeiro in 1961, in New York in 1963 and in London in 1965. Thus, for the first time in the history of the WMA, the voice of an exiled doctor was heard.

The international relations of the CMA extend to all countries of democratic persuasion and its representatives are officially invited to all the medical events and congresses in those countries.

Brief Review of the Cuban Medical Association Congresses and Post-Congresses in Exile

The first scientific, cultural and educational ac-

tivities of the CMA began in the year 1961 within a frame and dimension naturally limited by the necessities of the physicians at that time and progressed each year as the institution continued to grow.

Since 1969, the Cuban doctors in exile have been celebrating annually Cuban Medical Congresses and Post-Congresses of the highest scientific quality. The Cuban Medical Association in Exile and the Pan American Hospital are each in charge on alternate years of organizing the Congress or Convention and the Post-Congress or Post-Convention — the CMA on the odd years and the Pan American Hospital on the even years. More than two thousand physicians regularly attend these events, mainly Cubans but also North Americans, Latin Americans, and Europeans. Prestigious universities and medical organizations co-sponsor these congresses.

The CMA is proud that each congresses' outstanding guest faculty has included very prominent doctors from the U.S.A., Europe, Latin America and Asia and, of course, exiled Cuban physicians.

In the interests of objectivity and as a record for history, we feel that the opinions of our distinguished medical colleagues throughout the world who have attended these events speak more eloquently of the CMA Congresses and Post-Congresses and we include herewith excerpts from the comments received from those worthy colleagues:

Carl A. Hoffman, M.D., Former President of the AMA:

It is appropriate that you should be holding your convention at this time. A time associated in this country with liberty... courage... dedication to ideals. On the 4th of July, Americans hark back to when oppression and tyranny marred this land as they have your beloved Cuba.

Gerald D. Dorman, M.D., Acting Secretary - General of the WMA:

The Cuban medical profession has attained an outstanding position in this great American nation because of its quality and quantity.

Joseph H. Davis, M.D., Former President of the Dade County Medical Association:

The zeal and energy of the organizers of the Congress, particularly yourself, impressed me as an example of the diligence, hard work, and high professional standards brought to our shores by our Cuban colleagues.

Emanuel M. Papper, M.D., Vice President for Medical Affairs and Dean, the University of Miami School of Medicine:

You are certainly to be congratulated for the excellence of this program. I consider it a particular honor that I was privileged to participate.

Michael E. DeBakey, M.D., Baylor College of Medicine, Texas Medical Center:

I really enjoyed participating in your memorable meeting.

George E. Burch, M.D., Tulane University School of Medicine:

I was very impressed with the enthusiasm and the well-organized performance of the group. The number of doctors present was quite impressive.

George S. Palmer, M.D., Executive Director, State of Florida Board of Medical Examiners:

Let me congratulate you upon the wonderful meeting and the good attendance and wish you well in the future.

Denton A. Cooley, M.D., Cardiovascular Associates, Texas Heart Institute:

I was impressed by the enthusiasm of your group and their dedication to high purpose. You have my best wishes for achieving the goals which you have set for the association.

Pedro A. Castillo, M.D., highly respected and re-known Cuban Professor of Medicine throughout many generations:

The brilliant contribution of the Cuban physicians, the cooperation secured from the most renowned physicians of this country are just the final result of the outstanding task of the Cuban Medical Association in Exile.

Message

Our mission seems to be to turn the impossible into the possible and to offer this example to the cause of a better destiny for mankind. We always feel that we will someday have the opportunity, in our liberated country, of offering the warmest expressions of thanks to our medical colleagues and to all of those in the world who have drawn close to us to console us in our sorrow and pain and to stimulate us in our faith and in our fight. Until that time, our message to our North American colleagues and to our colleagues throughout the world is:

Don't forget Cuba enslaved!

The Cuban Medical Federation and the Cuban Medical Association (1925-1966), Its Struggles, Its Conquests, and Its Final Destruction by the Castro-Communist Regime

Augusto Fernandez-Conde, M.D.



Dr. Fernandez-Conde

Despite the fact that physicians everywhere have been enlivened with a deep sense of solidarity, in Cuba at the beginning of this century they did not join together to fight for the defense of the legitimate interests of the medical profession, as had already been done in Europe, North America and South America. By 1861 well known professionals founded the "Academia de Ciencias Fisicas y Naturales de La Habana." In one of their scientific meetings, Carlos J. Finlay presented his theory of the mosquito as the transmitting agent of yellow fever. Later on the "Sociedad de Estudios Clinicos de La Habana" was organized with the purpose of exchanging scientific information. Its members traveled through the island periodically giving conferences and conventions which served to increase the cultural level of the physicians. The "Sociedad de Socorros Mutuos" was also founded to improve the economic situation of the physicians and to better serve the Cuban people. From this society later emerged the "Circulo Medico de Cuba" based in Havana, whose function was strictly social. Sporadic attempts to form medical associations took place in various cities of the island, where physicians grouped together for the defense of their common interests, and to exchange medical knowledge. Among these the Medical Association of Cienfuegos was one of the first to be organized. The "Colegio Medico de Cuba," whose structure copied that of the American

Medical Association, had existed in Havana for many years. For several reasons, this association did not include the majority of physicians. However, its effectiveness was demonstrated when in 1924 it persuaded the Cuban Congress to approve a rudimentary "Ley de Colegiacion Medica Obligatoria," (Law of Compulsory Medical Membership"), that was vetoed by President Zayas.*

*"This law required that all Cuban physicians must become members of the Cuban Medical Association in order to be allowed to practice medicine. This was a means of bringing unity and power to the medical profession. All other professionals graduated in Cuba's universities started to have the same favorable criteria concerning compulsory membership in their respective associations. Therefore, when the new Cuban Constitution was proclaimed in 1940, a clause was included in it named "Colegiacion Obligatoria de los Profesionales Universitarios" (Compulsory Membership of the University Professionals), to be implemented by each professional association. The medical association implemented this clause in 1944 becoming the "Colegio Medico Nacional de Cuba."

The "Medical Federation of Cuba" was founded in 1925.

The spirit of reform that prevailed in Cuba in 1925 brought together a group of prestigious physicians whose purpose was to organize a successful campaign of recruitment throughout the island in order to constitute the "Federacion Medica de Cuba." That culminated in a great assembly that took place in the "Payret" theatre of Havana on October 24, 1925. The president of Cuba, Gerardo Machado, and more than two thousand physicians attended, and as a result of this meeting the "Cuban Medical Federation" was established.

The "Federacion Medica de Cuba" emerged as an urgent necessity because of the many problems faced by the practice of medicine in Cuba at that time. University curricula needed revision; the famous student strike of 1923 had already occurred in the University of Havana. Upon graduation, the

Dr. Fernandez-Conde, former President of the Cuban Medical Association (1954-1955) and former President-Elect of the World Medical Association (1955).

physician found his future uncertain not only because he was unable to improve his knowledge through internships or hospital residencies, but also because of poor financial remuneration which made it almost impossible for him to support himself and his family. Private practice was severely limited by the ample free service given in municipal and state hospitals, where on the other hand, physicians gave their services in return for very low salaries, and these jobs were at the mercy of politicians, who fired their occupants each time their political interests advised them to do so. Moreover, since the beginning of the Republic, there existed in Havana, and in the major cities of the island, the so-called "Regional Centers with Sanatoriums." These were pre-paid health care organizations, initiated by Spaniards and their descendants and clustered together according to the different regions of Spain they came from (Asturias, Galicia, Castilla, Cataluna, Andalucia, etc.). In these centers for a moderate monthly fee, not only hospital assistance was given but also medicines, house calls and outpatient diagnostic and therapeutic services. Physicians in these centers worked on a salary basis. It's true that they received a better salary than those in public hospitals, but working hours were excessive, and the number of patients to be examined and treated was exorbitant. All these negative factors were reflected in the quality of the work performed and in the treatment patients received. Physicians were everywhere frustrated with their working conditions, and with the shrinkage of opportunities for the practice of medicine.

First Action Taken. Physician strike.

The first executive Committee of the Medical Federation immediately studied the major problems that affected the medical profession and the health of the Cuban people: university education, brand name drugs, illegal and improper practice of medicine, pre-paid organizations for health care, public hygiene, legal medicine, and minimum salary for physicians. Proposals of solutions to these problems were presented to the government and to the Regional Centers. The Federation demanded from these Centers the settlement of collective work agreements in which the Centers guaranteed several demands concerning mutualism*, numbers of patients per hour of work to be seen by physicians, salary increases, and other matters of interest to the profession. In 1927 the first medical strike was declared

in the "Centro Gallego" of Havana, and the first division appeared when some of the physicians ignored the strike. President Machado personally intervened to partially solve the problem. In 1929 because of the suggestion to pay homage to President Machado for his efforts in this affair, numerous protests arose from the physicians. They now showed their disagreement—as did many of the people—with the policies of President Machado, who was trying to modify the Constitution to extend his tenure in office and his personal power. There were many protests against a government that was now giving signs of its dictatorial character. The University of Havana was closed and a student, Rafael Trejo, was killed in a fight with the police (1930). The repercussions were immediately felt all over Cuba, which from up to 1933 had to suffer a sanguinary tyranny. Many physicians were taken prisoner at this time because of their opposition to the government. This was of great concern to the Executive Medical Committee which tried to help them with little success.

Physicians' New Strike

In August of 1932 The Medical Federation declared another strike in the "Regional Centers" of Havana, Matanzas, Camaguey and Santiago de Cuba. The strike was in retaliation for the failure to comply with requirements of mutualism approved in the Second Medical Convention recently held. This strike caused another great division among physicians as many of them did not support it, and continued working, or replaced those on strike. Those who did not support the strike were expelled from the Federation.

The Fall of Machado. Government of Grau San Martin (1933)

On August 12, 1933, the fall of Machado's dictatorship* brought forth the resignation of leading physicians in the Cuban Medical Federation who had been accused of participating in the deposed regime. The triumphant revolution designated Carlos Manuel de Cespedes y Quesada** as "Provisional President" of Cuba.

*As the results of a general strike against the government, a rebellion in the armed forces and the mediation of the U.S. ambassador Sumner Welles, appointed by Franklin D. Roosevelt to help in the solution of the Cuban crisis.
 **He was the son of Carlos Manuel de Cespedes y del Castillo, a rich sugar plantation owner in Oriente Province, called the "Father of the Country" because he started on October 10, 1868, the first important war of independence against Spain which lasted 10 years. He became the first president of the Republic of Cuba in Arms, and was killed by the Spaniards in the Sierra Maestra on February 27, 1874.

*Eligibility of beneficiaries to be limited to people of moderate resources.

He had the support of the Army, the traditional political parties, the most important revolutionary groups (except the Directory of Students) and the U.S. Embassy. However, the President was deposed on September 4, 1933, by the so-called "revolution of the sergeants" headed by Fulgencio Batista, an unknown court stenographer and sergeant in the army, who rose to power as kingmaker and dictator of Cuba, a position he was to hold, in and out of office, for a quarter of a century. A transitory "Junta" (Pentarquia) ruled Cuba until September 10, 1933, when it chose one of its five members, Dr. Ramon Grau San Martin, professor of the school of Medicine, as president of the Republic. One of his first measures was to promulgate the "Law of Compulsory Membership for Physicians, Nurses and Midwives" in their respective professional organizations. This law gave the Medical Federation the authority to register all physicians, including those at the "Regional Centers" who had ignored the call to strike. These doctors were required to abandon their position but they refused. When the Cuban Medical Federation asked the government to help them enforce this mandate, the authorities refused to intervene because they were plagued by internal problems of their own.

Those problems culminated on January 15, 1934, in the ousting of President Grau San Martin by the then Colonel Batista with the cooperation of the American Embassy and the old political parties. Dr. Carlos Mendieta, a colonel of the independence war, was designated President. Three days after this appointment the Medical Federation declared a strike (this had been agreed to one month before) throughout the island. This new strike ended quickly when the new government promised to carry out the resolutions of the Federation, but it left the issue of mutualism to the arbitration of the Labor Section of the League of Nations. The following year, the League sided with the physicians on the issue, but no action was taken by the government.

Mendieta's Government. General Strike. Physicians Strike. Closing of the Medical Federation (1935).

The government of President Mendieta considered that the activities of the Federation were in opposition to it, particularly the declaration of general strike a few days after his inauguration. In November of 1934, the government suspended the Law of Compulsory Membership. In March of 1935, the Army occupied the University of Havana and the University Hospital, "Calixto Garcia," because of a

general strike against the government. Most physicians joined the strike following the order of the Federation, the only exceptions being those working in the Regional Centers. The government forces destroyed the quarters of the Federation, and on March 19, 1935, the Decree-Law 25 declared the "Cuban Medical Federation" illegal and terminated.

Reopening of the Federation (1937). The Emergence of "Accion Inmediata" Medical Party (1938).

The Executive Committee of Physicians continued acting clandestinely. In 1937, when the decree by which the Federation had been closed was declared unconstitutional, the association renewed its struggles. During this time, the medical classes of 1934, 1937 and 1938 joined other existing medical groups in order to create a new party, "Accion Inmediata", within the Cuban Medical Federation. In opposition to them, the old leaders organized the "Ortodoxo Federative" party, which continued to be the party of the majority of the medical profession until 1942. This year their principal leaders resigned the positions they had in the Executive Committee, in the face of the oppositionist thrust of "Accion Inmediata", and because of an internal crisis in their party. "Accion Inmediata", with a majority in the Executive Committee, was now the governing force in the Medical Federation. It gave impetus to the struggle in behalf of the medical community.

The Law of Compulsory Membership. The "Colegio Medico Nacional de Cuba" appears (1944).

In 1944, following the mandate of the 1940 Constitution, the government of the Republic promulgated a decree, which soon became a congressional law, ("Ley de Colegiacion Obligatoria de los Profesionales Universitarios"), establishing the compulsory membership in their respective associations of all university graduates. A National Medical Assembly was held in which the statutes and by-laws of the "Cuban Medical Association" ("Colegio Medico Nacional de Cuba") and of the Disciplinary Councils were approved. By mandate of the law physicians became members of the Cuban Medical Association, being obligated to follow and obey its decisions and resolutions. This facilitated the solution of the old conflict with the Regional Centers by means of an agreement subscribed between the Executive Committee of the Cuban Medical Association and the directors of the Regional Centers.

Physicians who violated these laws and other regulations of the Medical Association were sanctioned by the Disciplinary Councils which had the authority to suspend a physician from practicing his profession temporarily or permanently. These decisions could either be sanctioned or revoked by the Supreme Court of Justice.

Medical Gains Up to 1959

Many were the gains obtained by the physicians until 1959 such as: approval of a new Physicians Retirement Law; free medical care for physicians at the University Hospital, "Calixton Garcia," and at the "La Esperanza" Sanatorium for tuberculosis with the cost being defrayed by the Association's funds. Other gains were a new scale of salaries for private medical centers; an annual leave with full salary (one month for each eleven months of work); a 44-hour work week; and other social benefits stipulated in the prevailing labor legislation were extended to the physicians.

The construction of buildings for the local medical associations in major cities in the island, and the magnificent building of the Cuban and Havana Medical Associations were also among the new accomplishments. In addition, a Council for Foods, Drugs and Cosmetics was organized by the Association in order to supervise and control the quality of these products. Intensive scientific activity was developed by the Post-Graduate Medical Education Committee along with the cooperation from well known Cuban and foreign physicians, particularly from the United States, offering courses and conferences in Havana and in the rest of the island. Boards of specialties were organized to grant degrees in medical specialties to those who fulfilled the necessary requirements. Important studies were made on Health Careers, Hospital Administration and Forensic Medicine.

The Triumph of Fidel Castro, and the Cuban Medical Association (1959).

By 1959, the revolution initiated by Fidel Castro in the Sierra Maestra Mountains, years before, totally controlled Cuba. It had the almost absolute endorsement of the Cuban people. The courageous attitude of the Cuban Medical Association in defense of the physicians and the people, and its contributions to the revolution (hundreds of physicians fought in the mountains and in the cities in the underground movement) placed the Medical Association in a preponderant position among other professional organizations. However, professional

and labor organizations were the first to receive the ferocious attacks of the new government, which had initially given indications of democratic fervor, but later showed its dictatorial intentions and Communist militancy. The control of the professional and labor organizations was carefully planned from the beginning. Official interventions of labor unions, labor federations and professional associations were decreed, and headquarters buildings were assaulted claiming that these unions and associations had dealings with the previous regime. Revolutionaries, together with well known Communist leaders, were assigned to lead these unions and associations. The Cuban Medical Association received a different treatment than the usual procedure, although the objective of total control was the same. Soon it was known that the government was developing plans for physicians and for the health care in Cuba without the assistance and cooperation of the Cuban medical organization. A large number of communist physicians were placed in responsible positions within the ranks of the governmental organizations. Dismissals of medical personnel by the hundreds from governmental positions were decreed for political reasons. Faced with protests from the Medical Association, the government promised to provide a "Decalogue" of ten justified causes for dismissal, but this promise was soon ignored.

The "Revolutionary Medical Party". The Medical Assembly in Santiago de Cuba (1959).

With the objective of taking over the control of the Cuban Medical Association, physicians belonging to the "26 of July" and other revolutionary movements united with the communists and other dissidents of the medical party "Accion Inmediata" and formed the "Partido Medico de la Revolucion." All physicians working for the state, city, police or the army were forced to join this new medical party. Utilizing all kinds of coercion and threats this party set out to proselytize the physicians of the island in an effort to obtain a majority of delegates for the Medical Assembly to be held in December, 1959, in Santiago de Cuba. At this assembly the President and half of the Executive Committee would have to be elected. As an example of coercion in the province of Pinar del Rio a physician was jailed and accused of collaborating with the Batista regime in order to force him to vote in favor of the Revolutionary Party in the local medical election. (He was later condemned). Regardless of all the pressure exercised, the medical parties "Accion Inmediata" and "Unidad Federativa" won the elections in the

most important cities (Havana, Cardenas, Santiago de Cuba, Holguin, Santa Clara, Sancti Spiritus, Moron and others) and went to the Assembly with a clear majority of the delegates. It was easy to see at the Assembly that the "revolutionary" physicians, led by the Communists, were ready to use any measure necessary to attain their objective of controlling the medical association. Using threats of prison, dismissal or transferral of positions of the physicians working for the government, and by using physical threats with guns on the belts of their olive-green uniforms, they succeeded in keeping opposing delegates away, and forced others to vote for them. Only in this manner were they able to dominate debates that took place. But in spite of this cynical show of force the Communists won the election by only a thin margin of twelve votes out of a total of 650 delegates elected. Major Dr. Oscar Fernandez Mel, totally unknown to the medical profession, and confidant and companion in both the Sierra Maestra and the Escambray Mountains of the Argentine Communist Ernesto "Che" Guevara, was "elected" president.

Destruction of the Medical Institutions.

The destructive intentions of the new Executive Committee elected in Santiago de Cuba were soon evident. The brave and resisting efforts of the opposition forces formed by the few men of "Accion Inmediata" and "Unidad Federativa" who remained in the Executive Committee, and the new members recently elected, proved useless. Thus the Council of Food, Drugs and Cosmetics was terminated immediately. Any physician who had taken a stand in the election or in the Assembly of Santiago de Cuba was fired. A crisis in the faculty of the school of medicine was instigated. The medical militia was created, trying in a compulsory way to make every physician join it. Several prestigious physicians were expelled from the medical association and accused of collaboration with the Batista regime or of opposing the revolutionary government. Physicians were forced to sign the "Declaration of Havana"*.

Assets in the physician retirement fund were confiscated. In 1960, a National Medical Assembly controlled by the Castroites took place. In this assembly it was approved that physicians would not be permitted to leave the country, and those who had left, were to be considered expelled from the

Association and their office and belongings to be confiscated. Other approved resolutions were: to switch the functions of the medical association to the Medical Labor Confederation which was a branch of the Cuban Confederation of Labor, controlled by the Communists; to "donate" the buildings of the municipal medical associations to the revolution for "their better use in benefit of the people." All this caused the resignations of the leaders of the municipal medical associations during the years 1960-1961.

Attacks, Prison, Death, Exodus of Physicians. The Communist Cuban Medical Association declared itself "terminated."

From 1960, and especially since April 1961, the date of the Bay of Pigs invasion, the persecution against physicians increased in Cuba. A majority of physicians had adopted the position of opposing the government which had declared itself Marxist-Leninist. Hundreds of physicians joined their fellow Cubans as political prisoners. One of them, Dr. Eufemio Fernandez, an opposition militant, was executed. Others died in prison as a result of poor conditions and illnesses. After more than fifteen years there are still many physicians in jail. The new Cuban Medical Association instead of protecting its members, acted as their prosecutor. Respect for physicians disappeared. When the government moved to take over private hospitals and regional centers, the persecution extended to these private sectors. Physicians who did not cooperate were threatened with dismissals, harassment, or prison. The practice of medicine depended on decisions dictated from the Ministry of Health which totally controlled all medical activities. The government seized the drug companies and merged them into a single government controlled organism, which resulted in an alarming shortage of drugs. With the pretext of avoiding a loss of currency, the government suspended the import of foreign medical books and journals, except for those coming from behind the iron-curtain countries, which have traditionally been very poor in the development of medical science. Physicians had to work under a great deal of pressure in public as well as in private practice. The massive exodus of physicians abroad, especially to the United States, began. The government retaliated by placing restrictions on anyone wishing to leave the island. Doctors had to secure permission to leave from the Ministry of Health. Permission sometimes took several years to be granted. During

*A sort of a new Cuban Constitution presented (and approved unanimously) to the people of Cuba in a "mass concentration" in Havana, by Fidel Castro.

this waiting period, they were required to do "voluntary work" at locations prescribed by the Ministry. By 1963, more than 2,000 physicians had left Cuba, and twice that many had requested permission to leave. The grave medical crisis worried the government which promised not to socialize medicine. However, on November 27, 1963, medical students, interns and residents publicly repudiated private practice and promised not to exercise the private practice of medicine in the future. On January 15, 1964, the Council of Ministers approved a law prohibiting the private practice of medicine for all those graduating after the date the law became effective. Finally on May 10, 1966, the "Cuban Medical Association" declared itself terminated. It "donated" its belongings to the government, including its building, its large funds, records, and even its employees became employees of the Ministry of Health. The justification given for closing of the Medical Association was that "the revolution was giving the people and the physicians of Cuba all that they needed," and therefore the existence of a medical association representing the medical profession was no longer necessary.

Repercussions of the Exodus of Physicians on the Cuban Medicine.

The government attack on the medical profession and the subsequent exodus of thousands of highly qualified physicians reduced the quality of medical services in Cuba. To replace the physicians that were leaving, the government decided to push forward the graduation date of medical students. Intensive three month courses were instituted to replace the former one year courses. Secondary school and college education was required no longer to study medicine. The government encouraged

indoctrinated youths to enter the medical profession by making it easier to go into it. Since most of the medical faculty had left Cuba, the government appointed many incompetent doctors. Therefore, Communist physicians, nationals or foreigners, became professors of medicine. With an inexperienced faculty and the improvisation of the medical curriculum, the preparation of the new physicians suffered. The people referred to them at times as "premature doctors," or as "graduates of the Sierra Maestra," since graduation from medical school depended on the student hiking the Sierra Mountains situated on the southeastern part of the island. This had been the hiding place of Castro and his guerrillas during the military stage of the revolution. It is estimated that from 1960 to 1968, more than four thousand second-rate doctors graduated in Cuba, with a considerable lowering of the standards of medical practice and health care in the country. These facts along with an acute shortage of food-stuff, and a general hygienic decline, have contributed to an upsurge in several infectious diseases. The Communist government through its control of all the media of communications has tried to hide this fact.

Summary

In its totalitarian efforts to control every aspect of Cuban life, and because of the resistance of the medical profession, the Castro regime destroyed in 1966 the prestigious Cuban Medical Association established in 1925. All physicians were further coerced to belong to the Cuban Confederation of Labor. Persecution of doctors produced a massive exodus of them and forced the regime to improvise new physicians. The well-earned prestige of the Cuban medical profession came to a very low level.

The Profile of the Cuban Physician in Exile

Virgilio Beato, M.D.



Dr. Beato

verse at all; many were not able to bring proof of their educational achievements, or copies of their degrees; part of them came immediately after Castro's take-over, and more, traumatized by the difficulty of surviving under the new Communist regime, came later. A privileged few already had employment opportunities waiting for them in this country, but the vast majority had no idea what direction their careers would take. For the doctors who had a family, the difficulty of finding a means of support while studying for the necessary examinations presented a serious practical problem. For the older physician who had been established in his practice for many years, the required internship after passing the examinations constituted a tedious and uncomfortable situation.

In spite of these and other differences in their situations, the most common problem for the doctors was the language barrier. First, they had to understand enough English construction to enable them to pass the required examinations in order to be allowed to work in the United States; afterwards, however confident they may have been of their sound professional training, the near impossibility of conversing with a colleague or with a patient posed a serious threat to the success of their practice. The doctors have attacked and overcome the problem of language with a determination matched only by their dedication to medicine.

Dr. Beato, former Associate Professor of Medicine, University of Havana School of Medicine, and former full Clinical Professor of Medicine, University of Texas Medical School at San Antonio, Texas.

Perhaps the most diversification between the Cuban doctors occurs in their manner of gaining entry into the country. They escaped in planes, boats, through embassies, with concealed identities, etc., many were unsuccessful in their attempts. The following three anecdotes will illustrate this point:

Dr. A. was a practicing physician in Guantanamo, where he continued to work after Castro gained power, apparently passively agreeing with the limitations imposed by the Communist government. At one point he began to complain to his friends that he believed he must have an ulcer; he went to a clinic where he secured an x-ray from a patient with an acute ulcer, and showed it to his colleagues and to the government personnel as proof of his condition. In the following weeks, he went to the laboratory and had the physician take 500 cc. of his blood; he drank the blood, and, knowing he would soon regurgitate it, went to the hospital where he worked. Upon arriving at the hospital, he naturally began violently vomiting blood in front of various witnesses, and explaining that this was due to his ulcer. When the doctors urgently advised that he have surgery, he vehemently opposed anyone operating on him, insisting that he would only allow Dr. Alton Oschner, an old friend of his residing in New Orleans, to perform the operation. After many machinations, he finally secured special permission from the government to go to New Orleans for the emergency operation, and he hasn't left the United States since.

Dr. B. was a surgeon who, before the revolution, was a close friend of Fidel Castro and his entire family; naturally, after the overthrow, everyone expected him to go along with the new regime. He was working in a hospital in Santiago where he befriended a Dutch captain who explained to him exactly how to sail to Jamaica from Santiago de Cuba. He found a sailor who was also eager to flee the country, and together they stole out in the middle of the night, only to have the motor in the boat break down when they were a few miles out to sea. They frantically rowed back to land, barely

making it in time for the doctor to go to work the following morning. He showed up at the hospital as usual, performed his day's work, and that same night set out again, this time to make it safely to Jamaica. His wife and two daughters had come ahead of him and were waiting for him in the United States.

Dr. C. had engaged in antirevolutionary activity, and was held prisoner in a military fortress, El Castillo del Principe, in Havana. He knew that he would soon be sentenced and executed. In an effort to gain admittance to the hospital and stall for time enough to arrange an escape, he had another doctor secure some typhoid bacilli and inject them into pieces of candy. He ate all the infected candy, but for some reason did not contract typhoid, and was later executed.

The methods of escape, often created out of desperation, are as varied as the physicians now residing in the United States. Their forms of adjustment to a different language are also uniquely indi-

vidual. However, as a group, the Cuban doctors seem devoted, determined, and successful professionally, with a great deal to offer to the American communities of which they have become a part.

The Cuban physician has served in all different fields of American medicine. Several of them today are professors in different medical schools. A great number joined the staff of V.A. Hospitals in different categories, from chief of service to admitting office physician. Some have embraced a research career, and others the public health service. Psychiatric hospitals also utilize significant numbers of Cuban doctors, but the great majority of them have established themselves across the country, in small towns and big cities. If somebody were to look for a common profile for them, it would be found that the Cuban doctor, keeping alive his passion for his motherland, has learned to love the United States, as his second motherland, and bears profound gratitude to the country that allowed him to have work, a home, and freedom.

Postgraduate Program for Cuban Refugee Physicians

Rafael A. Penalver, M.D.

"Few experiences in education and education management have given me more personal satisfaction than the program carried out by the Office of International Medical Education of the University of Miami's School of Medicine." Dr. Henry King Stanford, President, University of Miami.



Dr. Penalver

The founders of the University of Miami had in mind an Inter-American university that would develop a vast plan of relations between the United States and Latin American countries. The very first University of Miami Bulletin (1926) stated: "The University of Miami is fortunately situated for

the purpose of acting as a clearing house for the intellectual interests of North and South America. It is its purpose to study the particular problems of both continents with the hope that it may be able to serve as an interpreter of each to the other." As a matter of fact, the official sub-title of the University of Miami is the "Pan-American University," which was engraved on the entrance plaque to the North Campus. For several years the University of Miami football and basketball teams played annual games against the University of Havana teams, alternating between Havana and Miami.

The University of Miami School of Medicine was established in 1952. In December 1954, I was invited to participate in a symposium on Industrial Medicine, organized by Dr. William B. Deichmann, Professor and Chairman, Department of Pharmacology. A sizable number of physicians from Latin America attended. Discussing the merits of this symposium brought forth the idea for the expanded

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Inter-American Conferences. In December 1955, Dr. Homer F. Marsh, Dean of the School of Medicine (1953-1961), Dr. W. B. Deichmann and Dr. Willard Machle went to Havana to formalize an agreement between the universities. The meeting was presided over by Dr. Clemente Inclan, Rector of the University of Havana. Dr. Angel Perez-Andre, Dean of the School of Medicine of Havana, Dr. Luis F. Rodriguez-Molina, Dr. Vicente Pardo-Castello and Dr. Rafael A. Penalver attended the meeting. It was agreed that greater success could be expected if the sessions were conducted with Spanish as the official language and alternating the conferences between Miami and Havana. With the attendance of twenty-four Cuban delegates, the Primera Conferencia Inter-Americana de Medicina del Trabajo was conducted as planned, September 3 to 7, 1956.

In 1961 nearly 700 Cuban physicians were in the United States as refugees. We were free to do almost anything except to practice medicine. Due to state licensing laws affecting foreigners who are not trained in the United States, many able Cuban physicians had to take jobs not related to the medical profession. Passing the Educational Commission—formerly Council—for Foreign Medical Graduates Examination is normally the first step that must be taken by a foreign medical graduate who wishes to practice in the country. The E.C.F.M.G. is designed as a comprehensive test of candidates knowledge in the principal fields of medicine. The medical portion is a one-day written examination which includes approximately 360 questions of the multiple choice type, and is given only in English. Part of the E.C.F.M.G. examination is a test of the candidate's ability to understand written English.

Working with the faculty of the School of Medicine of the University of Havana in Exile (see article written by Dr. Fernando Milanés), a three month refresher course was organized by the School of Medicine of Miami, under the leadership of Dr. Ralph Jones, Jr., Professor and Chairman, Department of Medicine. Substantial financial support, much of it anonymous, was offered by the Greater Miami community. Shortly thereafter, when the Cuban Refugee Emergency Program was set up by the United States Government, the University of Miami Medical Program received substantial federal support. Beginning early in 1962 the American Medical Association established the "Loan Fund for Exile Cuban Physicians at the University of Miami." While it was in operation 266 Cuban physicians borrowed \$137,500. Under the program they were eligible to borrow up to \$600 from a Miami bank,

with payments guaranteed. The postgraduate medical program was designed to provide the Cuban physicians in the shortest possible time a course of studies calculated to enable him to pass the standardized examination of the Education Commission for Foreign Medical Graduates. In addition to a refresher in basic medical-related sciences, and a review in the fields of medicine, preventive medicine, surgery, pediatrics, obstetrics and gynecology, the 12-week course incorporated study of English medical vocabulary, pronunciation and grammar, and was organized around medical case histories. The major objective of the course—to improve the capabilities of students to use English both for the purpose of passing the E.C.F.M.G. examination and for the purpose of keeping up with medical literature in the English language—was itself integrated with medical training. Credit should be given to Barry College, a Catholic women's college in Miami, and especially to Sister Mary Kenneth for participation in the program in English language instruction. I think it is a great credit to the University of Miami School of Medicine that this program was developed. The people of this country, including the growing Cuban refugee population, have been the beneficiaries of the program as well as the doctors. The Cuban refugee population would otherwise have had to find medical attention entirely with non-Cuban doctors in competition with Americans in a situation where medical doctors were already in short supply. In some areas of Cuban refugee concentration and most particularly in the Miami area, there would have certainly been precipitated a crisis in medical care. It is worth noting that during the period of this medical training program the output has been more than that of the Florida Medical schools. I will quote Howard H. Palmatier, Director of H.E.W.'s Cuban Refugee Program, who at the closing session of the seventeenth course said: "Important to the Cuban doctors, to this University of Miami and to the Cuban Refugee Program, are the services that you will render, not only to other Cubans, but to American citizens as well. In this connection I assure you that you can be very proud of the record that Cuban physicians have made in this country. Most of you are familiar with the fine record many of your colleagues are making in this community. Others outside of Florida are doing equally as well. I can also tell you of a large hospital in the southern part of this country that would not be open today were it not for the services of Cuban physicians. I dread to think of the many hundreds of citizens who would be without medical attention in

that situation. But they do have it—thanks to Cuban physicians prepared by the University of Miami. This knowledge of the professional ability of Cuban physicians has spread far and wide in the United States. Not a day goes by in our Washington office that we do not receive a call or a letter from a Senator, a Congressman, or a private citizen seeking information on how to employ or offer a practice to Cuban physicians. Generally, the request is prefaced with praise about the excellent work of Cuban physicians they know or have heard of.” Since 1961 the courses have been repeated every six months. The total enrollment of Cuban doctors (courses 1-34) is 2,393. The thirty-fifth course will be presented from October, 1977, through January, 1978.

The program that began as a narrowly oriented program to fill what was thought to be a temporary need arising from the arrival of Cuban physicians, has evolved into a broadly conceived program to meet a long range and important need for upgrading medical skills everywhere that Spanish is the common tongue, and many places where it is not. The program quickly acquired international importance. As long as 12 years ago, beginning with the ninth course in January, 1965, substantial numbers of Spanish speaking non-Cuban doctors began to enroll in the program. Today, 2117 non-Cuban doctors have attended these courses. They represent forty-one nations of the world—primarily Spanish speaking countries—but also including non-Spanish speaking countries as well, from England and Germany in Europe to Korea and Japan in Asia. As each class graduates we invite a leading medical educator from Latin America or Spain as a commencement speaker. The Dean of the School of Medicine and/or the Director of the Office of International Medical Education have participated in all the Pan-American Medical Conferences in medical education, sponsored by the Pan-American Federation of Associations of medical schools, since the first conference was presented in Bogota, Colombia, in 1966. Some of the physicians who have participated in these courses offered by the University of Miami School of Medicine are now among the leaders in the academic field and the practice of medicine in their homelands. We have been frequently honored with invitations to participate in the activities of their schools of medicine and their national medical congresses. We feel that much good will has been generated by these visits. Presently, the program has many ramifications beyond its original intent. The program provides

hands-across-the-sea relationships between the School of Medicine of Miami and physicians throughout the world far beyond its original purpose. In at least one case, participants were able to apply their training immediately to benefit their homeland. Eight Nicaraguan physicians that were enrolled in the course at the time of the earthquake that devastated Managua in 1972, returned to their country to give assistance under a specially designed program, that was a joint effort of the Office of International Medical Education, University of Miami School of Medicine and the University of Nicaragua Medical School. The six-month program was funded by a donation from International Telephone and Telegraph Corporation (ITT).

Because of the broad experience of the University of Miami School of Medicine in the field of training foreign-educated doctors, we have been selected to offer different programs, as the following:

The Florida State Board of Medical Examiners Continuing Education Program was organized to implement House Bill 3732, providing for the establishment of a continuing education program and the licensure of foreign professionals. Candidates are selected by the Florida State Board of Medical Examiners. Instruction is provided in Spanish by the faculty of the University of Miami School of Medicine. Successful completion of this course qualifies the physicians to present themselves for licensure examination for practice in the State of Florida and are accepted in lieu of the E.C.F.M.G. certificate. It is a nine month course. The total enrollment (1975-1977 courses) is 611 physicians. The great majority of participants were graduated from the School of Medicine of Havana.

Post-Doctoral Refresher Training Program for Foreign Medical Graduates. This course was sponsored by the National Health Services Corps, Department of Health, Education and Welfare. The course curriculum was designed to prepare the participants so as to enhance the likelihood of passing the examinations leading to licensure. This course was offered in English from October, 1974, to July, 1975. Physicians that participated in this program were graduated from schools of medicine in Argentina, Bangladesh, Bolivia, Bulgaria, China, Cuba, Egypt, England, France, India, Iran, Italy, Japan, Korea, Mexico, Pakistan, Peru, Philippines, Poland, Rumania, Spain, Switzerland, Turkey, and U.S.S.R.

Preparatory Course for the Federation Licensing Examination (FLEX). The Bureau of Health

Manpower, Health Resources Administration of the Department of Health, Education and Welfare, awarded a contract to the University of Miami for the development and administration of a preparatory course for the Federation Licensing Examination (FLEX). This program was offered in English from June to December, 1976. From the 565 applications that were received, 169 were found to have met all the requirements to be fully eligible. 86 were graduated from the University of Havana. Twelve other countries were represented in the course.

Indochinese Refugee Physician Program. Sponsored by the Division of Medicine, Bureau of Health Manpower, Health Resources Administration, Department of Health, Education and Welfare, preparatory courses were established in order to help Vietnamese and Cambodian refugee physicians pass the required examinations to practice in the United States. H.E.W. allocated more than 600 Indochinese physicians according to a geographical distribution throughout the United States. The University of Miami School of Medicine was responsible for conducting a course from March to July, 1976, with an enrollment of 80 physicians. Instruction was given in English. After completion of the course they took the Educational Commission for Foreign Medical Graduates Examination. Fourteen members of the faculty of this course were Cuban refugee physicians.

Postgraduate Program on Basic Medical Sciences for Cuban Dentists, Pharmacists and Veterinarians in Exile. Sponsored by the Cuban Refugee Program, Department of Health, Education and Welfare, and endorsed by the American Dental Association, the American Pharmaceutical Association and the American Veterinary Medical Association, this course was offered between January and March, 1966, with the attendance of 130 pharmacists, 88 dentists, and 32 veterinarians.

More than one hundred faculty members have lectured in these courses since they were established sixteen years ago. Only with their enthusiastic collaboration has it been possible to achieve what is previously reported. Due to space limitation, it is not possible to mention all the distinguished professors. Lecturing in the current (1977) courses are: Drs. Virgilio Beato, Jose S. Bocles, Frank L. Canosa, David Castaneda, Agustin W. Castellanos, Moises Chediak, William B. Deichmann, Jorge Echenique, Raul Echenique, Luis Fernandez Rocha, Raul de Gasperi, Jose C. Gros, Rene de la Huerta, Juan-Martin Leborgne, Adolfo Maldonado, Simon E. Markovich, Luis O. Martinez, Nelida G. Monal, Jose R. Montalvo, Lidio O. Mora, Gaston Morillo, Allan G. McLeod, Rafael A. Penalver, Fernando N. Perez-Montes, Alonso R. Portuondo, Juan M. Portuonda de Castro, Armando E. Ruiz-Leiro, Fernando Sala, George A. Tershakovec, Victor M. Torres, Manuel Viamonte and Fernando Vidal.

It has been my privilege to serve as President of the Florida Industrial Medical Association (1968-1969); of the Florida Society for Preventive Medicine of the Florida Medical Association (1975-1976); and since January, 1976, Member of the Consulting Editorial Staff of **The Journal of the**

Florida Medical Association.

Dr. Emanuel M. Papper, Vice President for Medical Affairs and Dean University of Miami School of Medicine, wrote as follows:

It is another source of satisfaction to note that graduates of our program, not content with attaining minimum licensure requirements have continued their studies and training. All the American medical specialty boards now number Cubans among their members. Cuban physicians appear as authors in the best medical journals and as lecturers at almost every medical meeting of the last ten years. . . . We are proud to include many Cuban physicians in the faculty of the University of Miami School of Medicine.

Brief Resume of the Hospitals and Numbers of Hospital Beds and an Outline of Social Legislation in Cuba

Eduardo Borrell Navarro, M.D.



Dr. Navarro

and Assistance (subsequently a Ministry), in the Cabinet of President Jose Miguel Gomez.

The above will prove that the men who governed Cuba and its legislators were in the early days of the twentieth century the men who understood most clearly that full enjoyment of health is one of the fundamental rights of all men, without distinction of race, religion, political ideas or economic or social condition. They also believed that adequate organization of health and public assistance services was the responsibility of the state. That the physician, who is an active participant in application of techniques of prevention and cure of all illnesses, and the community itself, which has the obligation of becoming acquainted with what it must do for prevention, must be disposed further to accept the measures indicated by the authorities, in order that the people can live in a society endowed with complete physical and social health.

In the complex and changing world in which we live today, organization and operation of hospitals and other health centers constitutes an essential

The Republic of Cuba, inaugurated on the 20th of May, 1902, has the privilege of having been the first Indoiberoamerican nation to have constituted its health services into a cabinet department. Thereby, Cuba was in 1909 the first country in the world to create a Department of Public Health

part of all medical assistance programs. Due to the evergrowing hypertrophy of medical sciences, it is indispensable that its practitioners, whether in general practice or specialists, can count on efficient hospital services. It is also generally acknowledged that the modern hospital has a most important part to play in all programs of social health and assistance, and, a further and very great indirect influence in the process of economic development of a nation. It must be noted that within a very few years—1902 to 1958—that is to say, only fifty-six years, Cuba attained a notable ranking among all nations of the new world in everything regarding public health and centers of assistance. Its several governments—and it had 10 different governments in that brief historic interval—did as much as they could in the noble work of development of the country's sanitary and public health activities. Some were more able, and perhaps others had greater resources at their disposal; but all were optimally intentioned as regards improving the level of public health and assistance.

In the brief space at our disposal it is impossible to make a historic description of the full process of development of Cuban hospitals during the free and democratic era Cuba enjoyed until December, 1958. But the succinct and modest character of this presentation will not prevent us from explaining as clearly as possible that the Cuban nation attained a position of the first rank in the universal stage in everything relating to public health, medicine and medical centers of assistance. Said position continued to improve until the black hour in which the totalitarian Marxist-Leninist system possessed itself of public power and plunged Cuba into one of the most absurd, decadent and negative periods of our history.

Our narration will also serve to refute the fallacious and mistaken allegations that the powerful

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propaganda apparatus of the Communist International has made on the history of Cuba prior to January 1, 1959.

The present totalitarian Cuban government has attempted to prove that the nation lacked sound health services and an efficient hospital organization. Therefore we believe it is opportune to indicate that the data and figures we quote below may be verified in the corresponding annals of the international organizations from which they were taken: the United Nations Organization (UNO), the Organization of the American States (OAS), the Pan American Health Office (PHO) and the World Health Organization (WHO) are trustees of the data contained herein. No distortions or semantic alterations have been made therein. They are all true and stand for posterity as evidence of the great efforts made by all governments of the pre-Castro period, always supported by the Cuban people in the Cyclopean struggle to assure that Cuba occupy a leading position in the specific fields of Latin American public health and social assistance.

To promote better understanding of this work, which covers the complete system of centers of assistance which the Cuban people had at their disposal up to December, 1958, we will divide it into two great historical stages. The first runs from the foundation of the Republic in 1902 to the end of the government of President Machado, in August, 1933, and the second stage begins in the latter year and ends in December, 1958, when the government of President Batista came to an end. The first republican stage covers 31 years and the administrations of Presidents Estrada Palma, Gomez, Menocal, Zayas and Machado, a second covers 25 years and includes the administrations of Presidents Gomez Arias, Laredo, Batista, Grau San Martin, Prio Socarras and again Batista. We do not mention the first provisional executives which held office for brief periods from 1933 to 1936.

During the first republican period (1902-1933) the Cuban people possessed 36 hospitals with a total of 6,893 beds. It is to be understood that all these installations were not built during the period, since many had been constructed prior to independence, which is to say, during the period of Spanish domination. For greater precision, we shall state that during the first Cuban administrations, only ten hospitals with 2,365 beds were created. The 26 remaining hospitals, with 4,528 beds, date from its era as a Spanish colony, and that of the Military Intervention of the United States.

It was in the second period (from 1933 to

1958) when the great increase and development of centers of assistance were attained. It is not to be doubted that the great industrial and commercial development which existed during this period contributed thereto, as did the increase of the size of the sugar industry (the principal source of national wealth), the U.S. sugar import quota having doubled during the period and provided a preferential price to Cuban sugar consisting of an increase of two cents per pound over the world market price.

The evident development of the country and the hard work and dynamic activity of the several administrations during those 25 years facilitated the creation of a very large number of hospitals and centers of assistance for the Cuban population. Thirty-six new hospitals were built in the period with fourteen thousand two hundred and forty-eight beds. Law No. 2077 of January, 1955, made a great contribution to the development of the services of public assistance, by creating an autonomous entity denominated the National Organization for State Hospital Administration. This had the mission of "establishing technical and practical methods in relation with the operation of hospitals and other centers of social assistance under state charge; attending to everything referring to propagation, construction, foundation, organization, and orientation of hospitals, and also acquisition of whatever equipment be necessary for present hospitals and for the operation of those of new creation."

The situation of hospitals and public assistance in Cuba, analyzed province by province in 1958 was as follows:

PINAR DEL RIO:

1. Civil Provincial Hospital (general). Existing in 1933 with 145 beds. A new building was constructed in 1944 and the number of beds increased to 200.
 2. Maternity and Infants' Clinic. An old building with 20 beds in 1933, a new building with 40 beds was built in 1941.
 3. ONDI (Organizacion Nacional de Dispensarios Infantiles) Provincial Hospital (pediatric), built in 1956 with 150 beds.
 4. Civil Hospital in Guanajay (general). An old building with 22 beds in 1933. A new hospital was finished in 1957 with 100 beds.
 5. "Pilar San Martin" Sanatorium (antituberculosis), at Guanito, with 150 beds. Increased to 400 beds in 1957.
 6. Four ONDI Dispensaries (pediatrics), in new buildings, with 24 beds in all.
- Pursuant to the above numbers, from 1933 to 1958, 727 new beds were provided in this Province of Pinar del Rio, which is to say an increase of 389 per cent.

LA HABANA:

1. National Hospital. Created in 1958 with a building possessing 500 beds.
2. Hospital "Calixto Garcia" known and built as Number One by the United States Military Government during the First Intervention period (1899-1902) with 1,000 beds. It was expanded to 1,300 beds in 1943. As of

- December 11, 1943, and by Presidential Decree #3610, it was transferred to the medical faculty of the University of Havana, although the maintenance expenses involved were within the jurisdiction of the national government budget.
3. Hospital "Las Animas" for contagious diseases. In 1933 it had 35 beds. In 1944 it was reconstructed and expanded to 110 beds. A new enlargement was made in 1956, reaching 160 beds.
 4. Hospital "Nuestra Senora de las Mercedes", founded under other names as early as 1597, had 180 beds in 1933. It was increased to 200 beds in 1942. In 1958 a new building was constructed to house this old hospital on land granted by the government. This had a capacity of 450 beds.
 5. "Instituto de Radium" (for cancerous patients). Dr. Juan Bruno Zayas, was built in 1920. In 1933, it had 45 beds. A new building was erected adjoining the "Nuestra Senora de las Mercedes Hospital," referred to above in 1958, increasing the number of beds to 90. It was built on land and with resources granted by the executive branch of the government.
 6. Hospital de Dementes de Cuba at Mazorra, near the capital city of Havana. In 1933 it had 3,000 beds. It was expanded in 1941 to 3,500 beds and in 1956 this figure was raised to 3,800 beds, with new wings and services being added.
 7. Hospital de San Lazaro, leprosarium, built at El Rinco, Santiago de las Vegas, near the city of Havana. It was inaugurated on February 26, 1917, under the Director-Manager-Treasuryship of Dr. Eduardo Borrell Ramos, father of this report's author. This new construction was destined to replace the old hospital situated in the center of old Havana. In 1933 it had 120 beds and was expanded to 334 beds in 1942.
 8. Sanatorio "La Esperanza" for tuberculosis patients. In 1933 it had 300 beds, which number was raised to 980 when the new "Lebrede Building" was constructed. In 1958, when an additional building of great capacity was erected (in order to take care of the patients who formerly lived in bungalows on the premises), it was raised to 1,380 beds.
 9. Hospital "Curie" of the Anticancer League, built in 1942 on land granted by the government. In 1933 it had 50 beds and these increased to 100 in 1944 and 140 in 1958.
 10. Clinica de Maternidad Obrera, devoted to obstetrics and gynecology, was erected in 1941 with 250 beds and expanded to 300 in 1957.
 11. Hospital Nacional Infantil for antituberculosis treatment, with 320 beds, was built by the Government in 1942.
 12. Hospital Nacional de la ONDI, built and inaugurated in 1958 with 400 beds.
 13. Hospital Nacional de la ONRI, or Organizacion Nacional de Rehabilitacion de Invalidos dealing with orthopedics and rehabilitation, was constructed in 1958, with 150 beds.
 14. Physical and Mental Rehabilitation Home, constructed in 1958, with a capacity of 250 beds.
 15. Hospital de la Liga Contra la Ceguera (Antibindness League Hospital) built by the government in 1958 with 60 beds.
 16. Instituto de Cirurgia Ortopedica built in 1944 as anti-polio myelitic institute with 120 beds. It was further expanded in 1957 to 150 beds.
 17. Instituto de Cirugia Cardiovascular annexed to the above in 1955, with 30 beds.
 18. Hospital Militar "Carlos J. Finlay", built and inaugurated in 1943, with a capacity of 1,000 beds.
 19. Hospital General de la Policia Nacional (National Police General Hospital), built in 1937 with its own building and 250 beds.
 20. Hospital Naval "10 de Marzo" constructed with 400 beds with its own building in 1958.
 21. Colonia Antituberculosa "Luis Ortega Bolanos," constructed at Cangrajas, Province of Havana in 1955 with a capacity of 500 beds.
 22. Two antituberculosis dispensaries for children, constructed in 1938, one in Cojimar and the other in San Miguel del Padron, (both in the Province of Havana), with a total capacity of 300 beds.
 23. Hospital "Lila Hidalgo" constructed and inaugurated in 1932 with a capacity of 85 beds. It was enlarged to 90 beds in 1944 and to 110 beds in 1956 with an adjoining blood bank. This hospital is situated at Rancho Boyeros, Province of Havana, and near the capital of the country.
 24. Hospital Civil de Guanabacoa. In 1933, this building had a capacity of 34 beds, which was increased to 56 beds in 1956 due to subsequent expansions.
 25. Hospital Civil de Guines. It had 30 beds in 1933 and was enlarged in 1941 to a capacity of 50 beds.
 26. Hospital Municipal de la Habana. Constructed in 1931, it was enlarged in 1935 to a capacity of 250 beds.
 27. Hospital Municipal de Emergencias "Fernando Freyre de Andrade". Constructed in 1915, it was expanded to 300 beds prior to 1933, and increased to 360 beds in 1957.
 28. Hospital Municipal de Maternidad. Constructed in 1930 with a capacity of 220 beds which was expanded in 1933 to 240 beds and in 1957 to 300 beds.
 29. Hospital Clinico-Quirurgico Municipal. Constructed by the Havana City Hall in 1957 with a capacity of 400 beds.
 30. Instituto Nacional de Cardiologia. Constructed under Government Decree #396 of February 13, 1953, for outpatients and operated under Sponsorship.
 31. Cantro de Rehabilitacion de Invalidos "Franklin D. Roosevelt". Constructed in Marianao, Province of Havana, under Sponsorship and with National Lottery funds, but operated by the national government.
 32. Hospital "Francisco Dominguez Roldan". Devoted to the treatment of cancer and adjoining the Curie Hospital referred to above.
 33. Organizacion Nacional de Dispensarios Infantiles. This institution was known as ONDI. Four dispensaries were erected in 1957 with a total capacity of 24 beds, and devoted to pediatrics.
- According to this report, between 1933 and 1958, the Province of Havana had an increase of 8,385 beds, equivalent to 155 per cent.
- MATANZAS:**
1. Hospital Civil Provincial "Santa Isabel y San Nicolas". In 1933, it had 102 beds which were increased to 200 beds in 1943, being totally reconstructed in 1956 to a capacity of 250 beds.
 2. Instituto de Homicultura de Matanzas. Built in 1928 and reconstructed in 1941 to a capacity of 100 beds.
 3. Hospital Civil "Santa Isabel". Situated in the city of Cardenas; in 1933 it had 100 beds. A new building was erected in 1957 with a capacity of 200 beds.
 4. Hospital Civil de "San Fernando". In the town of Colon, this hospital was increased from a capacity of 20 beds which it had in 1933 to 54 beds in 1941.
 5. Organizacion Nacional de Dispensarios Infantiles. Three dispensaries were erected in 1958 with a total capacity of 18 beds, and devoted to pediatrics. From 1933 to 1958, 415 new beds were created in the Province of Matanzas, representing an increase of 172 per cent.
- LAS VILLAS:**
1. Hospital Civil Provincial "San Juan de Dios" had 100 beds in 1933. Its capacity was increased to 154 beds in 1944. Was totally reconstructed in 1957 with space for 250 beds.
 2. Clinica de Maternidad Obrera, capacity increased from 50 to 60 beds in 1944.
 3. Hospital Provincial de la ONDI (Santa Clara) had its own building of 352 beds (pediatric) and 6 dispensaries with a total of 36 beds.
 4. Hospital Civil de Cienfuegos had 100 beds in 1933. In 1941 its capacity was increased to 132 beds. Totally reconstructed in 1958 with a capacity of 250 beds.

5. Hospital Civil de Remedios. Its capacity increased from 40 to 70 beds in 1941 when given a new building.
6. Hospital Civil de Sagua La Grande (Pucurull). Capacity increased from 100 beds in 1933 to 116 beds in 1943.
7. Hospital Civil de Sancti Spiritus. Its capacity increased from 40 beds in 1933 to 92 beds in 1942.
8. Hospital Civil de Yaguajay. Created in 1942 with 20 beds.
9. Hospital Belisario Batista in the Cienaga de Zapata, constructed by ONDI in 1957 with 30 beds for emergency care to farm workers.
10. Hospital Civil de Trinidad "Martha Fernandez Miranda". Its capacity increased from 25 beds in 1933 to 50 in 1944. Totally reconstructed in 1956 with a 185 bed capacity.
11. Hospital — Sanatorio Antituberculoso de "Topes de Collantes", Trinidad, constructed in 1944 and opened to the public in 1954 with a capacity of 1,000 beds. From 1933 to 1958 in Las Villas there was an increase of 2,002 beds that represented an increase of 431 per cent.
14. Hospital Civil de Victoria de las Tunas. Created in 1942 with 23 beds and with its new building in 1958 the bed capacity was increased to 100.
15. Five ONDI Dispensaries with a total capacity of 50 beds including the largest in Yateras because of its topographical situation. In Oriente, from 1933 to 1958, there was increment of 2,004 beds which represents a 495 per cent increase.

CAMAGUEY:

1. Hospital General de la Provincia. It had 165 beds in 1933. In 1941 it was expanded to 294 beds. In 1958 a new building was built with a capacity of 400 beds.
 2. Clinica de Maternidad Obrera, created in 1936 and in 1942 a new building was built with 60 beds.
 3. Hospital Infantil "San Juan de Dios", established by private enterprise, capacity of 60 beds.
 4. Sanatorio Antituberculoso "Amalia Simoni," new building created in 1958 with 100 beds.
 5. Hospital Civil de Ciego de Avila. Its capacity was expanded in 1933 from 20 beds to 59 beds in 1944. In 1958 a new building was created with a capacity of 150 beds.
 6. Hospital Civil de Moron. New building in 1943 of 100 beds.
 7. Five ONDI Dispensaries with a total of 30 beds, inaugurated in 1958.
- In Camaguey, from 1933 to 1958, there was an increment of 715 beds — a 386 per cent increase.

ORIENTE:

1. Hospital Civil de la Provincia. In 1933 it had 230 beds. In 1941 it was increased to 330 beds. A new hospital was built in 1958 with a 400 bed capacity.
2. Hospital Infantil. A new ward was built in 1941 for 40 beds.
3. Hospital Provincial de la ONDI, en Santiago de Cuba. New building created in 1958 with 352 beds.
4. Sanatorio Antituberculoso "Ambrosio Grillo", en el Cobre. New building created in 1941 with 360 beds.
5. Hospital "San Luis de Jagua" (leprosarium) en Alto Songo. New building created in 1943 with 400 beds.
6. Hospital Civil de Antilla. New building created in 1957 with 100 beds.
7. Hospital Civil de Baracoa. In 1933 it had a 30 bed capacity. In 1942 its capacity was increased to 46 beds.
8. Hospital Civil "Flor de la Caridad" in Banes. Created in 1941 with 86 beds. In 1956 a new building was created with 116 beds.
9. Hospital Civil de Bayamo. In 1933 its capacity was 30 beds. In 1943 its capacity was increased to 69 beds.
10. Hospital Civil de Gibara. In 1933 it had 5 beds. In 1941, 28 beds. A new building was created in 1957 with a 100 bed capacity.
11. Hospital Civil de Holguin. In 1933 it had 50 beds. A new building was created in 1942 with 100 beds.
12. Hospital Civil de Manzanillo. In 1933 it had 20 beds. In 1944 it had 40 beds. In 1958 a new building was created with a 100 bed capacity.
13. Hospital Civil de Guantanamo. Its bed capacity was increased from 50 beds in 1933 to 76 beds in 1942.

It should also be mentioned that the principal cities of Cuba had First Aid Centers "Casa de Socorros" maintained by the municipalities, offering emergency clinical and surgical assistance. Havana had 14 of these centers and Marianao six. Other cities had centers as required by the population ranging between one and five aid centers. Inasmuch as it has been omitted under the Havana Province, it should be stated that on the Isle of Pines there existed a civil hospital of one hundred beds and various private clinics.

In this account of gradual hospital development, we should add that private initiative was not far behind and assisted the government in the important task of giving professional help to the Cuban people. The private sector in Cuba was responsible for two hundred and fifty medical centers which were known as villas, "quintas", regional centers, clinics, institutes, etc.

The number of beds of all of these organizations totaled fifteen thousand. The majority of them were structured upon a mutual aid basis that permitted them to establish enormous sanatoriums in the capital, with numerous facilities throughout the country, that were responsible for giving the member emergency medical attention until he or she could be placed in the proper medical facility. The referred to data indicates that there were no less than one-half million individuals in all of the Republic that were associated with this type of mutual aid medicine. For a modest fee that was less than five pesos (then the equivalent of dollars) they had available medical centers with magnificent medical and surgical services.

The superb clinics or hospitals known as "La Benefica", "La Covadonga" and of the Asociacion Canaria, to name but a few were of Spanish origin. The multiple assistance centers were backed and directed by Cubans among which we mention the following: "Centro Medico-Quirurgico de Trabajadores de Cuba", "Clinica Antonetti", "Sagrado Corazon", "Centro Medico Quirurgico", "Clinica Miramar," and "Asociacion Cubana de Beneficencia." All of them offered brilliant assistance in the task of developing and incrementing Cuban medical science, efficiently contributing at the scientific

seminars and national and international medical congresses that took place in Cuba during the country's period of democratic republicanism.

Taking into consideration the corps of assistance centers of both governmental and private initiative, we find that the people of Cuba had at its disposition 35,000 beds for 6,630,921 inhabitants. This figure averaged one bed for each one hundred ninety inhabitants in the year 1958, which is superior to the one bed for each two hundred persons, that the more civilized and progressive nations of the world have at their disposition.

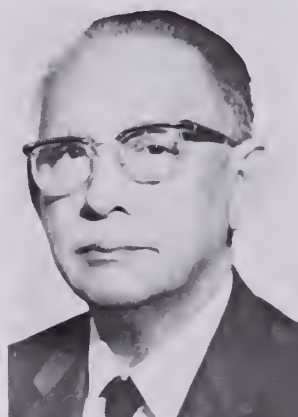
The Cuban social laws referring to public health and hygiene are the most advanced in the universe. It not being possible to cite all of them, we mention the eight-hour work day; the law determining closure of drug stores and pharmacies; the law covering on-the-job accidents; awarding one month rest for each eleven of work and the right of full salary

during illness; regulation of women's work and that of children; maternity insurance; professional insurance for doctors and for male and female nurses; child protection in all its aspects via the National Organization of Infant Dispensaries (ONDI) and for invalids and disabled through the National Organization of Rehabilitation of Invalids (ONRI); school dining rooms (ONCEP) that distributed breakfast to all who attended public schools and many others that would make interminable this modest recapitulation.

This concise review would of itself be sufficient to put in perspective that Cuba until 1959 was one of the cleanest and healthiest countries of this earth and that public health in our homeland was always a constant and dynamic concern of all the governments that succeeded one another to power from 1902 until the arrival of Marx-Leninist totalitarianism.

Resume of the History of Cuban Medical Research

Agustin W. Castellanos, M.D.



Dr. Castellanos

The first quarter of this century, when Cuba was still emerging from the colonialism, this country was specially noted for having many physicians who were outstanding observers and having an advanced medical culture. But as in many other countries during the same period, they lacked the necessary techniques and instruments. In the last 50 years the most important investigations were born out of the University of Havana School of Medicine, the former Hospital Reina Mercedes, the Hospital Calixto Garcia, and mostly from the Hospital Municipal de la Infancia de la Habana, which was affiliated with the Pediatric Department of

Havana University School of Medicine. No less important were the works done at the Hospital Infantil Antituberculoso, and at the Hospital Las Animas for infectious disease.

Four decades ago child mortality was very high in the island due to the gastrointestinal disorders caused by the poor public hygiene and the lack of proper sewage systems. For this reason, the Pediatric Department of the School of Medicine and the Cuban Pediatric Society (founded in 1928) started a special research (clinical and laboratory) in this field of medicine.

Prof. A. A. Aballi takes the credit for having been the first to demonstrate the existence of shigellosis in Cuba. With the technical collaboration of bacteriologists R. Marquez and J. Martinez Cruz, he isolated first the *Shigella bacillus* and the other varieties successively: flexner, sonnei, duval, etc. (Bol. Soc. Cub. Ped. 1936). In 1937 the same researchers demonstrated that the outbreak at the Hospital Municipal de Maternidad of Havana was due to a *Salmonella* variety. Curbelo, Aballi, Sala

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and J. Martinez Cruz isolated the Havana Salmonella (Arch. Cub. Ped. 1951) and other pediatricians with the aid of the same bacteriologists discovered the eastborn, selonda, cholera suis, derby and london Salmonellas in 1944. In 1950 the georgia type was found for the first time in the human being by A. Curbelo y Marquez (Arch. Med. Inf. XIX, 195, 1972).

Dehydration and the electrolyte disorders were first described in gastrointestinal disorders by Prof. Hurtado in 1929 and 1930 (Bol. Soc. Cub. Ped.) with special remarks on metabolic alkalosis and acidosis. After that Hurtado (Bol. Soc. Cub. Ped. 1948), R. Martin Jimenez, G. Cardelle and M. Garcia Vazquez studied the electrolyte disorders, specially those of potassium (Rev. Cub. Ped. 1954). A. A. Aballi made a global study of the acute diarrhea problems (Bol. Soc. Cub. Ped. 1948).

The vitamin deficiencies were amply studied. A. A. Aballi described acute beriberi in the Cuban infant (1940). He also described the digestive disorders due to the lack of vitamin B complex factors (1940); and the cardiovascular manifestations also due to avitaminosis B in the Cuban child with R. Perez de los Reyes, H. de la Torre and J. A. Junco, cardiologists, as collaborators (1945). In 1950 he described the metabolic disturbances of the carbohydrates in infantile malnutrition. A. W. Castellanos and J. Beato studied carotinosi and vitamin A in infancy (Arch. Med. Inf. 1941). They incidentally discovered the cure of Hand-Schuller-Christian disease with a single massive dose of vitamin A (Vida Nueva, 1942). Vitamin C was extensively studied by T. Valledor (1940-1943).

The parasitology field was thoroughly studied. Worthwhile to mention are the works of Pedro Khouri, who wrote a chapter in Gradward's book. He discovered that the eosinophilic tropical syndrome described by Prof. T. Valledor (Bol. Soc. Cub. Ped. 1942) was due to the sheep's Fasciola hepatica (1935-1943). He discovered the healing effect of gentian violet in human strongyloidiasis (1936). He also discovered a new type of platyhelminth which was named after him.

A. W. Castellanos and A. Vazquez Pausa described the highly beneficial effect of iron ammonia citrate in the treatment of severe trichocephaliasis. J. G. Basnuevo and F. Borges successfully treated trichocephaliasis with hexylresorcinol by enema (Arch. Cub. Med. Top. y Paras. 1951). A. W. Castellanos, O. Garcia, E. Prado, and R. Montero discovered the cure of human balantidiasis with bacitracin (1950). Toxoplasmosis was verified in

Cuba when R. Martin Jimenez diagnosed a case with Dr. I. Embil, G. Cardelle and F. Sala, (Arch. Med. Inf. 26, 1957). After the initial work of Juan Grau Triana and J. Alfonso, both Prof. B. Saenz' disciples, L. Blanco and De Laosa discovered the etiological agent of pinta in 1947, and Blanco inoculated himself in order to study the incubation period and the primary lesions (Amer. J. Syph. Gonorr. and Venereal Dis. 31:600, 1947).

Hematology had a flow of new and valuable contributions. Alejandro Chediak recommended a method of diagnosis of syphilis with only one drop of dried and defibrinated blood, this method was afterwards used in many other countries (Arch. Med. Inf. 1932). A. Sellek and A. Frade studied the blood groups in Cuba (Rev. Med. Cub. 1933) as did J. A. Clerch (1948). In 1944 A. W. Castellanos introduced the packed red cell transfusion (Revista Vida Nueva, 1944). This method is universally used nowadays. Moises Chediak studying the leukocytic alterations, discovered the disease named after him Chediak-Higashi syndrome (Rev. Hematol 7:362, 1952).

A. A. Aballi with S. DeLamerens, A. J. Banus and Rosenwaiz studied hemorrhagic disease of the newborn. Their works were published in the Am. J. of Dis. of Child. in 1957, 1959 and 1962. They studied vitamin K and P.T.C. (factor IX) and were able to demonstrate the deficiency of the Stuart factor in this disease. Dr. Aballi founded the Neonatology Center where these and many other studies were done.

In the serologic field Antonio Sellek and Alejandro del Frade originated in 1939 a new flocculation test for the diagnosis of congenital syphilis (Bol. Soc. Ped. No. 8, 1939). They introduced this method in many countries and published more than 20 papers about it. They also created later a new test for hepatic dysfunction utilizing copper acetate (Rev. Cub. de Lab. Clin. No. 1, 1956). Both tests were routinely done at the Hospital Municipal de la Infancia of Havana until 1959.

In gastroenterology very important studies were done at the Chair of General Pathology. Prof. F. Milanes published (1930) in Europe his studies about the origin of bile "B". In 1935 he published another book, Tropical Sprue. From 1944 to 1947 he worked with T. D. Spies on folic acid and sprue. In 1950 he published another paper about nutritional diarrheas. In all he wrote no less than 65 papers.

In hepatology Virgilio Beato in 1954 (Rev. Cub. de Gastro-Enterol) wrote a paper, "Hepatography and Hepatomanometry." In the International Con-

gress of Radiology held in Mexico City in 1956, he presented a paper on venous and arterial hepatography.

Prof. J. M. Martinez Canas was the pioneer of electrocardiography in Cuba in 1919, and in 1923 he published in the Journal of Rio de Janeiro an original method, the electrophonocardiography. In 1936 he compiled his experiences regarding non-invasive methods and published the monograph "Clinical Estetography" (Rev. Vida Nueva, 1936) showing exceedingly good tracings of the diastolic bruits of mitral stenosis. Ramon Aixala created a device for the simultaneous registry of the apex-cardiogram and the phonocardiogram, and was given the honorary mention at the VIII National Medical Congress in Havana, 1939. Together with P. Rabina and P. Fojo he created the dorsal leads (Arch. Inst. Nac. Cardiol. Mexico, 1948). He described for the first time in cardiology the concordant displacement of the S-T (+) segment in the standard leads with an axis of S-T lesion of more than 60°. With P. L. Farinas they wrote a paper compiling their observations on "Cardiovascular Radiokimography" (Arch. de Med. Int. 1936), and together with L. Ortega and J. Planas they published their studies on ventriculokimograms (Arch. Med. Int. 1935). Later on, Agustin Castellanos, Jr. with Azan Cano, J. M. Calvino, and N. Taquechel extensively researched vectorcardiography in infancy (Rev. Cub. Ped. 1956) with the Frank method in normal beings (Rev. Cub. Cardiol. 1957), in cases of right ventricular hypertrophy, in congenital cardiopathies (1958), in the left ventricular hypertrophies and left bundle branch block (1957), (Arch. Med. Inf. 1958), and also in the undernourished child (Journ. of Ped. 54:293, 1959).

The radiologic diagnosis of the cardiovascular diseases has been the issue of numerous and successful investigations. In 1937 A. Castellanos, R. Pereiras and A. Garcia Lopez presented their first paper on radioopaque angiocardiology (Arch. de la Soc. de Estudios V1. fr ls Hab, Sept.-Oct., 1937) based upon research begun in 1931.

In January, 1938, they published a monograph both in English and Spanish on angiocardiology in the child. Their objective was to diagnose the congenital cardiopathies in the cadaver and living child. Castellanos and Pereiras originated the counter-current aortography (Rev. Cub. de Cardiol. 1939). Another paper was published on the value of retrograde aortography for the diagnosis of coarctation of the aorta (Arch. Med. Inf. 1942). In 1938 they published 10 more articles in Latin America and

Europe about this method, most of them in English. With this method were diagnosed the first cases of ductus arteriosus in childhood. They also described the superior cavography (Arch. Latino-Americanos de Cardiol. and Hematol., Mexico, D.F.) and the inferior cavography (Arch. de Med. Int. Cuba). Up to 1947 the authors used to carry out these procedures by peripheral venous injections, but after that date they performed the radioopaque injection through a catheter. In 1941 P. L. Farinas, working with dogs, demonstrated the innocuity of the abdominal aortography opacifying thru a previous cut down of the femoral artery in the inguinal region (Amer. Journ. of Roentg. 46, 641, 1941). Later on R. Bustamante, E. Perez Stable, E. Guerra and B. Milanes worked together on thoracic and abdominal aortography at the University Hospital of Havana. I. Cullhede of Sweden gave them the credit for being the first to diagnose aortic insufficiency in a human being by the method of injecting the dye with a catheter thru the ascending aorta.

In 1951 E. F. Ponsdomenech and Virgilio Beato made the percutaneous puncture of the right ventricular cavities in patients (Cardioangiography Preceded by Experimental Studies, Amer. Heart J. 41: 643, 1951). F. Barreras, Chief of the Cardiopulmonary Department at the National Institute of Cardiovascular and Thoracic Surgery, established in 1957, made numerous studies of pre and postoperative hemodynamics (1951-1958). Otto Garcia introduced cardiac catheterization and hemodynamic studies in cardiac children in 1951. The group of R. Bustamante and E. Perez Stable at the Hospital Universitario Calixto Garcia performed many coronary angiograms publishing one of their first papers in Mexico (Arch. del Inst. Nac. de Cardiol. 20:350, 1950).

Cardiovascular surgery was first performed in Cuba by A. Rodriguez Diaz and collaborators, H. Anido, R. Guiral and others (1946). He also worked on extracorporeal circulation utilizing first a heart-lung machine made in Cuba and later on using the Lilliehei apparatus.

In ophthalmology G. Cepero and Lorenzo Comas introduced medical diathermy in ophthalmology, publishing 36 articles (Revista Cubana de Oftalmologia, 1930). Since 1956 they have investigated intensively on contact lenses and invented the CON-LISH that was patented in Washington in 1961. When the Hospital Municipal de Infancia de la Habana was founded the Virology and Rickettsia Laboratory was under the direction of Dr. Juan Embil and under the supervision of Dr. M. Schaeffer from

Alabama. In those days poliomyelitis and coxsackie virus were the most important studies done. Herpangina was diagnosed by the doctors but without laboratory confirmation (G. Cardelle: Nueva Entidad Morbida, Comunicacion Preliminar. Col. de F. Cao, J. Embil and R. Plasencia, Arch. Med. Inf. XXI, 239, 1954). J. Embil was able to make the immunobiologic classification of the virus (Rev. Cub. Lab. Clin. VIII, 108:1954). Forty-three cases confirmed by the laboratory were reported in 1954 (G. Cardelle, R. Martin-Jimenez, Embil and F. Cao., Rev. Cub. Ped. 1954).

Clinical and serological studies about the response from the Cuban child to the antipoliomyelitis oral vaccine with an attenuated virus (the virus was facilitated and controlled by M. Schaeffer) were reported. The asptic or lymphocytic benign meningitis was studied by R. Martin-Jimenez (Rev. Cub. Ped. 22:495, 1960). M. Schaeffer achieved the isolation of the virus in infants (Arch. Med. Inf. XXIII, 86, 1953). A. Curbelo and V. Marquez were able to rapidly identify the influenza virus (Arch. Med. Inf. XXII, 337, 1954). J. Romulo Calvet and Gonzalez Herrera introduced the treatment of diphtheria with penicillin without the use of the antitoxin. Their first publication in this regard was in 1953 (Med. Latina and Bol. del Col. Med. Habana, 1953) and this method was soon of general use in Cuba and other countries.

In dermatology, Dr Pardo Castello studied especially the diseases of the nails about which he published a book in English (Diseases of the Nails 3rd Ed., Springfield, Ill., Chas. C. Thomas, 1960). He also wrote a book on dermatology that is used as textbook in many medical schools in Latin America.

A giant of the medicolegal investigations was Israel Castellanos. His studies on forensic medicine made him four times the winner of the "Canongo" prize given by the Sciences Academy of Havana, and he was also recipient of the Lombroso prize from Italy in 1928. His investigations from blood stains, human semen, perspiration and human hair made him world-famous in criminology.

In radiology, Pedro L. Farinas since 1936 made studies with radiokimography in general, with

special emphasis on cardiovascular studies for which he associated with Dr. A. Aixala (ventriculokimogram) in being the pioneers in Latin America. G. Elizondo Martell and F. Aguirre introduced tomography. A. Castellanos and Raul Pereiras introduced artificial anterior pneumomediastinum which they applied in infants and adults (Arch. Soc. Est. Clin. No. 3, 327, 1938) until 1958. In 1971 A. Castellanos received the annual prize "Critical Reviews in Radiological Sciences" in U.S.A. for his investigations using this technique. Cineangiography was started in Cuba by P. L. Castro and Castellanos and it allowed the application of the carbon dioxide angiocardiology in congenital cardiopathies (Rev. Cub. Cardiol. 19, 1963, 1958).

In internal medicine Prof. Pedro Castillo established his own school. He wrote books about the hemogram, cardiac infarction, liver diseases, and one on lung cancer. He organized a research laboratory to study the collagen diseases, particularly lupus erythematosus. He founded the Revista de Medicina Interna, which published many original investigations by internists and cardiologists (1928-1959).

In cancerology, Prof. Nicolas Puentes Duany was internationally known for being a great diagnostician, and the author of numerous papers, but he also worked very arduously in the treatment of this disease. We cannot forget to mention the following professors, who made very important and interesting contributions to the investigative world of medicine; Luis Ortega and Enrique Saladrigas, clinical professors; Manuel Viamonte, radiologist; Carlos Cardenas, internist; Pedro Iglesias Betancourt, medical pathologist; Jose Centurion, internist; Ricardo Nunez Portuondo, surgeon; M. Costales Latatu, surgeon; Clemente Inclan, experimental pathologist and pediatrician; Gustavo Cuervo Rubio, obstetrician-gynecologist; Clemente Inclan, orthoped; Jose A. Presno, surgeon. There are many others who made significant contributions but the limits of space preclude their being listed.

As set forth in this resume, Cuba was not only known to be a consumer of foreign medicine, but also was an exporter of methods, techniques and discoveries in all branches of medicine.

Founding and Activities of the Cuban Scientific and Medical Societies

Frank L. Canosa, M.D.-F.A.C.P.-F.A.C.C.-F.A.C.A.



Dr. Canosa

This society was, throughout its long history of over three quarters of a century, the center of medical culture in our country. Through this society, the outstanding contributions of each medical generation became known and it was also the brilliant flame of medical knowledge and clinical investigation. It was a center of clinical studies, where all doctors gathered, both the young and recently graduated, and those who were senior in the professional practice, to show the results of their work in the daily dealings with patients. The history of the "Sociedad de Estudios Clinicos de la Habana," emphasizes in its long life, the history of Cuban medicine.

Let us go back in the nineteenth century to the year 1878, when the war ended with the Zanjón Pact. At that time, those who had fled began their return, tranquility reigned, the Cuban social spirit lived again, and both Cubans and Spaniards began the reconstruction of the fatherland. During the following years an intellectual movement of great importance began in our country's culture. A large group of writers, philosophers, speakers, artists and scientific men gave glory and light to the national culture. The Cuban medical doctors were a part of

the exceptional movement, offering their participation to Dr. Serafin Gallardo's initiative in the creation of the Havana Society of Clinical Studies. The initial meeting of this society took place on October 11, 1879. The Academy of Medical, Physical and Natural Sciences, which had been founded in 1861 by the illustrious Don Nicolas Jose Gutierrez represented the center of scientific activity. However, because of its official character, it was always busy with the frequent consultations presented by public service. For that reason, it became necessary to create a specialized clinical studies organization for those who practiced the medical profession. There was a need for a medical society for the practicing doctor and for the young doctor, to provide a forum for the bedside observation of patients. This completely clinical orientation, which resulted in the creation of the Society for Clinical Studies is what distinguishes it from other medical associations.

Since its founding in 1879, during the colonial period, Cubans and Spaniards worked closely together in the Society of Clinical Studies. There was never a case where a member was attacked by another member because of his political philosophy, either inside or outside of the society. Respect, tolerance and fraternity among the members is the patrimony that we have received from those great men, and we have been able to maintain this during our lifetime, as a symbol of our moral sense and our high culture.

The regular technical sessions of the society were traditionally held, for over 75 years, on the third Thursday of each month, in the headquarters of the Academy of Sciences in the old San Agustin Convent. Our society was the center of medical progress. It was there that medical progress was proven and where professional reputations were established and consolidated. From its inception, it was in the society that progress of each era was recorded throughout the generations, long before

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they became known through other sources.

The society always had the participation of young doctors, together with the experience of those who had advanced through life and clinical medicine. Because of this special composition, the society filled a role transcendental to Cuban medicine. The society began publishing its proceedings in 1882, during the presidential terms of Don Antonio Mestre. They hold the history of Cuban medicine and keep in their glorious pages the immortal works of Carlos J. Finlay, Tamayo, Coronado, Santos Fernandez, Castro, Jacobsen, Lebrede, Cabrera-Saavedra, Plasencia, Menocal, Casuso, Aballi, Montoro, Farinas, Inclan, Castellanos and so many others that gave so much light and prestige to Cuban medicine in the last century and in this one.

Volumes of the proceedings of the society (Archivos de la Sociedad de Estudios Clinicos de la Habana), as well as the Cuban medical journal "Vida Nueva" edited by the late Dr. Octavio Montoro, and Frank L. Canosa, M.D. are gathered at the Calder Library of the University of Miami.

The Society of Clinical Studies of Havana maintains its historical position in the National Medical Congresses, in accordance with its objective of improving the scientific standard and the professional relations within the medical profession. It did this through its role under the auspices of these national medical congresses.

Our society held the first regional medical congress in Havana on January 15, 1890. Later, in the Republic, the society organized and held the first National Medical Congress in 1905. As a coincidence, on the exact day and month (May 23, 1905 - May 23, 1955) we organized and held, during our presidential term in the society, the 50th anniversary of the National Medical Congresses which culminated in the IX National Medical Congress, with Dr. Julio Sanguily, its executive director.

The Society of Clinical Studies of Havana, dean of the Cuban scientific societies, will continue to develop in the near future the scientific and cultural purposes for which it is destined. The memories of those who died will be forever treasured in the works preserved by the society. To become worthy of this, we are exerting our efforts, and the greatest tribute we can render to its memory is to continue in the path of work, patriotism and love of medical science.

The "Sociedad de Estudios Clinicos de la Habana" celebrated the "Oracion Cabrera Saavedra" in December, 1950, with conferences presented by our unforgettable friend and brilliant cardiologist of

international fame, Dr. Paul D. White. He practiced Spanish phonetics during the two days preceding his conferences on "Coronary Heart Disease in Mid-Century" and "Cor Pulmonale." Dr. White made his presentation in correct Spanish.

During the presidency of Dr. Frank L. Canosa, "La Sociedad de Estudios Clinicos de la Habana" held a solemn session commemorating the 75th anniversary of its founding. This session was held at the "Paraninfo of the Academia de Ciencias Medicas, Fisicas y Naturales de la Habana" (The Academy of Medical, Physical and Natural Sciences of Havana) on December 21, 1954. In this session, twelve members of the society were awarded honors, and plaques were presented to these distinguished medical professors, for their valuable services to medicine and to the society.

Lastly, we refer to our contribution in the "Historia de los Congresos Medicos Nacionales" (History of the National Medical Congresses) presented at the IX National Medical Congress and published in its proceedings of 1955.

Before the onset of the decade of the twenties of the current century, Cuban physicians, surgeons and specialists met, presented and discussed scientific matters in the Sociedad de Estudios Clinicos de la Habana, in state hospitals and in private clinics. In the decade of the twenties, we see the founding in Cuba of societies specialized in internal medicine and its subspecialties.

The **Sociedad Cubana de Gastrotenterologia** (The Cuban Society of Gastroenterology) was founded on April 3, 1922. Its first president was the brilliant clinician and professor of the University of Havana, Dr. Federico Solano Ramos. This first Cuban Society of Gastroenterology was short lived, lasting only one year. Nonetheless, in this short time, the society was able to accomplish significant things for the specialty by stimulating its study and practice. Many Cuban doctors attended specialized courses in Cuba, the U.S. and Europe and specialists groups were formed in hospitals, clinics and other scientific centers.

The Sociedad Cubana de Gastroenterologia reappears on November 10, 1949, with the first board of governors composed of Dr. Pedro A. Barillas, President; Dr. Fernando Milanés, Vice-President; Dr. Laureano Falla, Treasurer; Dr. Orlando de los Heros, Secretary; and Drs. Hector Madariaga, Amado Gabriel and Jose Lluch as board members.

Among the members of this society were the internationally known Professors Henry L. Bockus, Gallart y Monés, and Walter Alvarez.

The **Sociedad Cubana de Cardiologia** (The Cuban Society of Cardiology) was founded on September 11, 1937, in a memorable meeting held in the offices of the medical journal "Vida Nueva" (New Life) located in the Manzana de Gomez across the street from the Central Park in Havana. A group of noted Cuban cardiologists were brought together by Dr. Octavio Montoro, director of that journal, to obtain their assistance in the section of the journal dedicated to cardiovascular clinics and pathology. The group took advantage of the meeting to officially organize a group of Cuban cardiologists thereby founding the Sociedad Cubana de Cardiologia. Ten months later the Cuban Journal of Cardiology (Revista Cubana de Cardiologia) was founded in March, 1938. The editor-in-chief, Dr. Ramon Aixala, a brilliant cardiologist, was also one of the founding members and enthusiastic participant in the society.

Among the founders of the society we find other brilliant members of the Cuban medical profession, including Dr. Jose Martinez Cana, Dr. Octavio Montoro, a great lover of cardiology since his introduction to medicine who came to the U.S.A. to study the technique and interpretation of electrocardiograms and was a good friend of Pardee, Levine, and others and who introduced the first electrocardiograph (Hindle) to Cuba; Dr. Rodolfo Perez de los Reyes; Dr. Jose Bisbe Alberni; Dr. Filomeno Rodriguez Acosta; Dr. Carlos Gomez Gonzalez; and Dr. Luis Ortega Verdes. The V Interamerican Congress of Cardiology was held in Havana in November, 1956, with great success. Among the participants were world known cardiologists such as Paul D. White of Boston, Carlos J. Wiggers of Cleveland, Gustave Nylin of Sweden, Alberto Taquini and Blas Moia of Argentina, and Demetrio Sodi Pallares and Ignacio Chavez of Mexico.



Members of Honor of the Society of Clinical Studies of Havana at the 75th Anniversary of its founding. From L. to R. Alberto Inclan Costa, Ricardo Nunez Portuondo, Jose Ramirez Olivella, Gustavo Cuervo Rubio, Horacio Ferrer Diaz, Vincente Pardo Castello, Octavio Montoro Saladrigas, Gonzalo Pedroso Montalvo, Luis F. Rodriguez Molina, Jose Bisbe Alberni Pedro A. Castillo Martinez.

The Sociedad Cubana de Endocrinologia (Cuban Society of Endocrinology), the youngest of our societies was founded June 25, 1953. The study of endocrinology in Cuba goes back to the last century with the works of Romy, 1813, and Sanchez Rubio, 1816 (Hermaphroditism); Precocious Puberty by Costales in 1841; and Valdez Anciano described the first known case of infantile acromegaly in 1897.

Cuban doctors experimented with ACTH and cortisone; and were among the first international authors on the subject. Among them were Garcia Lopez, Montoro, Spies, Milanés, Lopez Toca and Reboredo, among others.

In 1919, Dr. Octavio Montoro introduced the first metabolimeter to Cuba, and in 1921 presented metabolic figures for the Cuban population. These figures were later confirmed by Villaverde and Duran Quevedo in 1946. The treatment of hyperthyroidism was studied by Frank Canosa (Thiouracil, 1945) and J. F. Schutte (Fluor, 1935).

The Sociedad Cubana de Pediatría (Cuban Society of Pediatrics). This society, which was founded in 1928, is discussed more completely in the paper of Dr. J. Beato elsewhere in this issue.

The Sociedad Cubana de Radiología y Fisioterapia (Cuban Society of Radiology and Physical Therapy) was founded by a group of prestigious and internationally renowned radiologists. Among them were Drs. Pedro L. Farinas (who died very early in life), Francisco Dominguez Roldan, J. Manuel Viamonte, Clemente Rodriguez Remus, Raul Pereiras, and Ricardo Hernandez Beguerie. This society was proud to have Dr. Agustin Castellanos, the illustrious pediatrician, professor and researcher, as an honorary member; he was the creator of the study of the heart cavities and the great vessels through the intravenous injection of the appropriate opaque substances. Angiocardiology was created and made popular by Dr. Castellanos in 1935. The bronchographic studies specially adapted to the early diagnosis of bronchogenic carcinoma made by Dr. Pedro L. Farinas are considered to be the single most important contribution credited to Cuban radiology.

The Sociedad de Neurología y Psiquiatría (Cuban Society of Neurology and Psychiatry) was founded in 1925. Later, as the result of its membership growth, and the progress of neuro-psychiatry, several subspecialty organizations appear. Among them are the Sociedad Cubana de Psicoterapia (Cuban Society of Psychotherapy), Sociedad Cubana de Psicoanálisis (Cuban Society of Psychoanalysis), Liga Cubana Contra la Epilepsia (Cuban Society Against

Epilepsy), y La Liga Cubana de Higiene Mental (Cuban Mental Hygiene League).

The Sociedad Cubana de Dermatología y Sifilografía (Cuban Society of Dermatology and Sifilography) was founded May 9, 1928, through the efforts of Dr. Vincente Pardo Castello, who was a famous figure in the field. A year later marks the first edition of the Bulletin of the Sociedad Cubana de Dermatología y Sifilografía. This was a quarterly publication that enjoyed great national and international prestige. This society was composed of many prestigious Cuban dermatologists, among them Drs. Pardo Castello, Castro Palmino, Braulio Saenz, Raimundo Menocal, Juan Jose Mestre, Ismael Ferrer, Roberto Quero, Juan Grau Triana, Pastor Farinas, Alberto Oteiza and many others.

The Sociedad Nacional de Cirugía (National Surgical Society) was founded in 1928. This society included general surgery as well as the surgical subspecialties such as: ophthalmology, obstetrics and gynecology, otorhinolaryngology, urology, orthopedics and traumatology.

Ophthalmology, which was essentially created in Cuba by the admirable Dr. Juan Santos Fernandez, was also successfully practiced by Drs. E. Lopez, Rodolfo Giral, Horacio Ferrer, Pedro Lamothe, Dehogues, Finlay (Jr.), Gutierrez, Francisco Maria Fernandez, Penichet. Primary ophthalmology was not limited to the study of refraction defects, but also our specialists performed all types of surgery on the visual organ, including nervous and brain diseases that were so brilliantly studied in Cuba.

The Sociedad Cubana de Obstetricia y Ginecología (Cuban Society of Obstetrics and Gynecology). This society was founded in April, 1939 and discussed in Dr. Julio Ortiz Perez' paper elsewhere in this issue.

The Sociedad Cubana de Oto-Laringología (Cuban Society of Otorhinolaryngology) was founded in 1926, and its first president was Dr. Eduardo R. Arellano. This society was the goal of all Cuban laryngologists, even though in the nineteenth century, many years prior to its founding, we had brilliant specialists. Among them were Dr. Carlos Desvernine y Galdos, who was born in 1852, and published many research studies. Dr. Emilio Martinez y Martinez was a true creator and a force in Cuban otorhinolaryngology. He was born in Havana in 1864, and formed a large and long lasting school of otorhinolaryngologists. Dr. Claudio Basterrechea, Dr. E. Martinez Perez Vento, Dr. Jose Gros (who

still practices in Miami with renewed strength), Dr. Rufino Moreno (recently deceased), Dr. Miguel Abalo, Dr. Alberto Codinach (in a Cuban jail). Dr. Enrique Fernandez Soto, a fine gentleman of great culture, was a strong member of this society, and is one of the pioneers of bronchoesophagology in Cuba (1916) with Drs. Martinez (father and son) and Basterrechea. He was called by Dr. Montoro "The Prince of Cuban Otorhinolaryngology."

The Sociedad Cubana de Urologia (Cuban Society of Urology) was founded in 1940 with Dr. Luis F. Rodriguez Molina as the first president and Dr. Luis Ajamil as the first secretary. The second president was Dr. Gonzalo Pedroso, followed by other great Cuban urologists such as Hernandez Ibanez, Seguro, Roberto Pedroso, Enrique Anglada, Jorge Cuellar, and others.

The Sociedad Cubana de Urologia is relatively recent; however, the history of urology in Cuba goes back to 1837. It begins with Dr. Tomas Montes de Oca and the founder of the Academia de Ciencias Medicas, Fisicas y Naturales de la Havana, Dr. Nicolas Jose Gutierrez who practiced the "Talla Hipogastrica" in Cuba for the first time in 1842. These facts are very impressive when we realize that at the end of our War of Independence there were only two specialties in Cuba: ear, nose and throat, and eyes.

The Sociedad Cubana de Orthopedia y Traumatologia (Cuban Society of Orthopedics and Traumatology) was founded March 6, 1944, by a group of doctors that included Armando Guerrero, Rafael Penalver, Alberto Inclan, Luis Iglesias de la Torre, Harry Romney, Demetrio Despaigue, Jose I. Tarafa,

Pedro Sanchez Toledo, Alberto Barba Inclan, and Jose Perez Lorie. The objectives of the society were: "To favor the study and development of orthopedics and traumatology, foster closer professional relations among those that follow this area of surgery, and assure the strictest code of morals and integrity within the specialty."

The society began its life by paying tribute to its most brilliant figures, and especially to Dr. Enrique Porto, who began the practice of orthopedics in Cuba in the Nuestra Senora de las Mercedes Hospital. Dr. Armando Guerrero was appointed Honorary President and Dr. Alberto Inclan was appointed President for Life.

Many other scientific societies also contributed enormously to scientific progress, among them the **Sociedad Cubana de Angiologia** (Cuban Society of Angiology), founded on February 16, 1953, through the efforts of Drs. Bernardo Milanés and Armando Nunez; the **Sociedad Cubana de Leprologia** (Cuban Society of Leprology) founded May 4, 1951, and affiliated with the International Leprosy Society; **Sociedad Cubana de Cosmetologia** (Cuban Society of Cosmetology), and **Sociedad Cubana de Medicina Aeronautica** (Cuban Society of Aeronautical Medicine) of which we are very proud because it was the first society of its kind in Latin America.

A totalitarian political regime can shut the voices of knowledge for a time, but not for all time. With the spirit of self-sacrifice and love of knowledge that has always been the hallmark of our profession, I can foresee happier and more brilliant days than the ones mentioned earlier. Let us continue with our contribution to the moral and material improvement of our medical profession.

Brief History of Surgery in Cuba

Juan C. Bolivar, M.D.



Dr. Bolivar

twentieth century (1900-1959) represents the third period.

During the three centuries of dark age, surgery was stumbling against the educational inertia of the metropolis. The University of Havana, founded in 1721, did not include in its curriculum anatomy, physiology, pathology or therapeutics until 114 years later when the university was secularized by Governor Jeronimo Valdes. In the meantime the authorization to practice medicine or surgery could be granted to those who attended the hospitals or assisted a well accredited physician. The first hospital was built in Santiago de Cuba in the year 1527. It was during this period that Dr. Gamarra migrated from Alcala de Henares, Spain, and established the medical practice on the island.

The second period was a transitional stage from 1824 to 1900 during which a bridge of strenuous surgical effort spanned the dark centurial past and the remarkable progress of the twentieth century. For 75 years Cuban surgeons traveled mostly to France and Germany to complete their surgical training. They were abreast of the principal surgical innovations and were anxious to overcome the colonial intellectual gap due to the slow erosion of the Spanish world power and to the historical isolation of Iberia. Isolated reports of successful surgical operations included a herniotomy for strangulated hernia (Thomas Montes de Oca, 1822). The importance of knowledge in anatomy was emphasized

by the creation of a Museum of Anatomy (Alonso Fernandez, 1822).

In reality teaching of surgery was initiated in 1824 by Gonzalez del Valle in the Royal University of Havana. Soon the results of different operations were being reported; Herniotomy for strangulated hernia (Antonio Miyaga, 1825, and Alonso Fernandez, 1828), lithotripsy, extraction of cataracts, resection of sternomastoid muscle (Manuel Valdes Miranda), cesarean section post-mortem, amputations, and arterial ligation for aneurysms were reported occasionally.

The introduction of general anesthesia in 1846, a few months after Morton successfully demonstrated the use of ether at the Massachusetts General Hospital, and the adoption of antiseptic principles made possible the extraordinary development of surgery in Cuba during the latter half of the nineteenth century. Breast amputations and parotidectomies were performed by Guillermo Diaz in 1860. Urologic surgery made a fresh beginning with Gonzalez del Valle. Almost simultaneously Guillermo Diaz performed an embryotomy, and Marcos Rojas operated on a vaginal fistula in 1866. Two years later Maximiliano Galan succeeded in performing an embryotomy with mother alive. Abdominal surgery initiated its rapid development: Landeta performed an enterotomy; Zayas aspirated an ovarian cyst; and Guillermo Diaz excised a hydatid cyst in 1867. In 1869 surgeons were performing orthopedic procedures: resection of the maxilla (Guillermo Diaz) and hip disarticulation (Plasencia).

The year 1839 had seen the publication written in Cuba of "A Treaty of Surgical Technique" by Nicholas J. Gutierrez. Nine years later (1848), "An Ophthalmic Monograph" was published by J. M. Morillas. The knowledge of topographic or regional anatomy was emphasized by Jose Varela Zequeira in his publication on inguinal herniorrhaphy technique and by Francisco Dominguez Roldan in his book, *The Thorax and Its Regions*. The surgical turnover, the desirability of comparing results, and the necessity of surgical information were shown in the growing number of medico-surgical publications and journals:

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Repertorio Medico (1843), *Anales de la Academia de Ciencia Medicas, Fisicas y Naturales de la Habana* (1864), *Cronico Medico-quirurgica de la Habana* (1875), *Archivos de la Sociedad de Estudios Clinicos* (1881), *Revista de Ciencias Medicas* (1886), *Progreso Medico* (1889), *Archivos de la Policlinica* (1892), and *la Revista de Medicina y Cirugia de la Habana* (1896). However, up to 1887 only 28 abdominal operations had been recorded.

An important event occurred in 1880 when J. M. Castaneda and Gabriel Casuso inaugurated the first operation suite provided with listerian principles at the so-called Quinta Nacional de Higiene. This greatly contributed to the development of surgery in Cuba during the remaining few years of the nineteenth century. The number of operations increased almost 150 percent in 10 years (1880-1890). The operative mortality was still high (40 percent). The replacement of antisepsis by asepsis, the introduction of the use of gloves and the construction of modern hospitals made possible a reduction of mortality and morbidity.

At the end of the nineteenth century, three large hospitals were under construction: the new Hospital Nuestra Senora de las Mercedes inaugurated by Emiliano Nunez de Villavicencio in 1886; the Alfonso XII Hospital built a few years later, called Hospital Numero Uno during the North American intervention; and the Calixto Garcia Hospital created in 1900 by the initiative of Enrique Nunez y Palomino. The latter included 19 buildings, with a surgical unit and an autopsy room. The surgical unit antedated the present surgical intensive care units.

The third period of Cuban surgical development (1900-1959) was influenced by the independence of Cuba. Surgery in Cuba in the first half of the twentieth century evolved simultaneously with the world surgery, realizing that the tremendous advance in surgical knowledge necessitated specialization in the various branches of surgical specialities. The number of hospital facilities increased in the metropolitan area of Havana. For the one million and five hundred thousand inhabitants there were approximately fifty hospitals (excluding dispensaries and emergency ambulatory centers); one hospital facility for thirty thousand inhabitants. Besides the general hospitals, there were specialized hospitals.

The Hospital Gral. Freire de Andrade for the care of injured patients was built in 1929. The Hospital Infantil and the Angel Arturo Aballi Hospital were the main children's hospitals. Thoracic sur-

gery was performed at the Sanatorio La Esperanza in Havana and the Ambrosio Grillo Hospital in Santiago de Cuba; El Hospital Tope de Collantes in Santa Clara was as a monument recalling the therapeutic past of pulmonary tuberculosis. An orthopedic hospital and a cardiovascular center were located in Havana. Surgical oncology had three hospitals in Havana: Juan Bruno Zayas, Cancer Hospital, and Curie Hospital. Two additional cancer memorial facilities had been donated by Eutimio Falla and the Schuegg Bacardi family in Santa Clara and Santiago de Cuba, respectively.

Finally in 1957 the county of Havana built the Medico-Quirurgico Hospital with 250 beds to provide care for charity and private patients. This modern facility included a burn unit, intensive care unit (surgical and coronary), renal dialysis section, skin bank, blood bank, central oxygen, and central air conditioning. New hospitals were built in several other cities. In Santiago de Cuba the National Hospital replaced the old colonial Hospital Saturnino Lora. In addition to federal, national, provincial, and community hospitals, there were nonprofit organizations and prepaid centers created by Spanish immigrants. These institutions performed a significant amount of good surgery. They were scattered throughout the island.

Bernardo Moas performed in 1907 the first suture of the heart at the Purisima Concepcion Hospital and Antonio Rodriguez Diaz performed the first successful operation of a Fallot tetralogy in 1948 at the Clinica Cardona, a Cuban prepaid hospital similar to the Kaiser foundation.

University hospitals, community hospitals, and specialized centers distributed in the principal cities of Cuba participated in the undergraduate and postgraduate training program. The expansion of the number of surgical facilities promoted a rapid development in surgical activities throughout the country.

Francisco Pla first performed an appendectomy in 1893 (Murphy and McBurney described their incision in 1893) and Ramon Bueno reported three appendectomies in 1901 (*Revista Medica Cubana*). Jose Antonio Presno first introduced spinal anesthesia in 1901; the same year a Department of Animal Experimental Surgery was created by Francisco Dominguez. Biliary surgery was first performed by Jose Antonio Presno. The first successful gastrectomy was performed by Jose Lastra and Ricardo Nunez. In surgery of the pancreas, the first pancreatoduodenectomy was reported by Antonio Rodriguez Diaz.

Abdominal surgery was rapidly developed by

Gonzalo Arotegui, Benigno Souza, Luis Rodriguez Baz, Tomas Armstrong, Vicente Banet, Raimundo Menocal, Pedro Pablo Nobo, Manuel Costales Latatu, Amador Guerra, Francisco Leza, Elpidio Stincer to name only a few. The remarkable skill of Enrique Fortun in clinical surgical diagnosis has been matched by only a privileged few. His superb teaching ability has been demonstrated by the performance of his trainees: Rogelio Barata, Manuel Huerigo Pino, Hilario Anido, Manuel Iriondo, Armando Nunez, Rafael Nobo, and Angel Giral. General surgery was developed also in other medical centers throughout Cuba.

In Santiago de Cuba, the first capital of Cuba, Donato Gonzalez Marmol developed an excellent training program. During his internship he reported his experiences with 100 spinal anesthetics in 1909. In 1907 he first performed a palliative cholecystojejunostomy for carcinoma of the pancreas. He published 42 surgical papers. The practice of surgery in Oriente Province was greatly enhanced by Eduardo Guernica, Jose Antonio Ortiz, Rafael Parlade, Vincente Guasch, Emilio Posada, Leon Hirtzel, and Antonio Freixes.

The foundation of pediatric surgery was laid in the children's hospitals by Jose Lastra, Francisco Monteavaro, and Antonio Carbonel, who first performed a ligation of a ductus arteriosus in a child. The surgery of congenital malformations was developed later by Angel Giral, Enrique Echevarria and Octavio de Marchena. Castellanos Foundation for Research in Pediatrics was donated by Agustin Castellanos (recipient of the Gold Medal of American Radiology Association). Pediatric orthopedics was greatly developed by Pedro Sanchez Toledo and Justo Pausa.

Obstetrics and gynecology teaching was founded by Serapio Arteaga at the old De Paula Hospital. The foundation of modern obstetrics and gynecology teaching was laid by Gabriel Casuso. Eusebio Hernandez was appointed Chairman of Obstetrics and Gynecology in 1900. Antonio Sanchez Bustamante, Ernesto Aragon, Jose Ramirez Olivella, Julio Ortiz Perez, Hector Rocamora, and Gustavo Cuervo Rubio made important contributions and trained excellent surgeons. The Hospital de Maternidad America Arias was built in Havana in 1930. The Maternity Insurance Labor Law founded a large maternity hospital in Havana soon followed by five other maternity hospitals in each provincial capital.

Three main centers of urology were located in Havana: one in the Hospital de Emergencia under the leadership of Gonzalo Pedroso (first Cuban urol-

ogist to obtain the certification of the American Board of Urology); the second one in the Hospital Universitario with Luis Rodriguez Molina and Luis Ajamil; and the third one in the Hospital Mercedes where Jose Iglesias developed his cystourethroscope, so well known in the United States of America.

Marked advances were made in otorhinolaryngology and neck surgery at three important institutions: University Hospital, Freire de Andrade Hospital and Curie Cancer Hospital by Claudio Basterrachea, Emilio Martinez, Emilio Martinez II, Jose Gros, Arturo Ojeda, Emilio Arellano, and Federico Fuste. Significant contributions to the development of otorhinolaryngology were also made by Fernandez Soto, Pedro Hernandez Gonzalo, and Rufino Moreno.

Orthopedic surgery was firmly established by Alberto Inclan and associates at Mercedes Hospital. In addition, Jose I. Tarfa at the University Hospital and Iglesias at the Military Hospital made outstanding contributions in trauma surgery.

The foundation of thoracic surgery in the twentieth century was laid by Gustavo Bergnes at La Esperanza Hospital. The first successful pneumonectomy was performed by Antonio Rodriguez Diaz in 1944. The field of thoracic surgery was continually expanded by Ernesto Iglesias, Jose Lastra, Vincente Banet, Rogelia Barata, and Juan Bolivar.

The groundwork for cardiovascular surgery was laid by Antonio Rodriguez Diaz. He first operated successfully on a ductus arteriosus in an adult in 1948. In 1950, Rodriguez Diaz and his associates, Hilario Anido and Angel Giral, presented to the International Cardiology Congress fifty cases of operations performed upon cardiovascular malformations. By his initiative a cardiovascular research unit was created where Frank Barreras, Guido Ascanio and Dominguez worked on animal models. There in 1957 the same investigators developed a rudimentary pump for open heart surgery.

The development of neurosurgery in Cuba commenced with Carlos Ramirez Corria who attended Clovis Vincens neurosurgical service in Paris in 1935. Neurosurgery rapidly progressed and was well established by a group of valuable neurosurgeons trained in the United States: Alonso Collar, Luis Suarez Fernandez, Efrain Marrero, Francisco Garcia Bengochea, Enrique Bravo and Jorge Picaza. Four of the above mentioned have the neurosurgery board certification.

Surgical oncology became a reality in 1928 with the construction of a cancer hospital in Havana. The care of cancer patients advanced rapidly throughout the country by the further construction

of the already mentioned cancer facilities. At the Curie Hospital supported by the Cancer League, a nonprofit organization, a breast cancer service was developed by Nicanor Martinez Bandujo. Substantial advances in the combined modality treatment of head and neck cancer were made at the head and neck division. The thoracic and general surgery sections made rapid advances in the field of surgical oncology. The first pelvic exenterations were performed in 1952. Lung and esophageal cancer surgery was developed since 1950. Between 1945 and 1959 at least 800 chest operations (excluding heart) and about 250 surgical procedures upon the esophagus were performed in one of the sections of the surgery department of the Cancer Hospital. The continuous expansion of oncology was possible because of the national, spontaneous support of the Cuban people through the Cuban Cancer League.

One of the most important factors in the development and progress of surgery in Cuba was the creation of blood banks. Blood transfusions have been used in Cuba since 1912. Three thousand and

five hundred blood transfusions were carried out in one children's hospital in three years (1935-1938). A National Blood Bank was founded by Gonzalo Arostegui in 1945. The first 500 units of plasma were donated to the United States Army a few months before the end of World War II.

The high standard of surgery in Cuba on December 31, 1958, has been shown in the United States of America by the Cuban surgeons who did not hesitate to take specialty boards. There are at least 75 Cuban surgeons certified by the American Board of Surgery and by American Boards of different specialties.

We are only too conscious of the difficulty in evaluation of the status of surgery in Cuba today. We are greatly handicapped by the lack of any reliable source of information about the course taken by surgery after 1959. What does appear undeniable is that the teaching and training of surgeons has been greatly crippled by intermingling surgical science with an imposed one-track mind philosophy incompatible with real progress.

Notes on the Evolution of Medicine in Colonial Cuba

Gilberto R. Cepero, M.D.



Dr. Cepero

Appointed by Queen Isabel on Columbus' second voyage to the New World, Diego Alvarez de Chancas was the first doctor of medicine that went to Cuba. A navy physician, he wrote a remarkable description of an indigenous infectious disease unknown in Europe. Called *poulicantina* by the Ca-

ribs, *cocolitzle* by the Aztecs, and *xecxic* by the Mayans, all these names have a common meaning: black vomit. Four hundred years later, based on Dr. Chancas' findings, Dr. Carlos J. Finlay of Havana for the first time proposed that yellow fever originated in the Central American forests.

In 1569 Dr. Gamarra started his practice in Havana, and in 1610 Dr. Juan Tejado was nominated municipal physician. The University of Havana was founded in 1736. At the end of the eighteenth century, Dr. Tomas Romay introduced Jenner's vaccination against smallpox, provoking an attack upon his home by a group of zealous anticontagionists. This irrational act resulted in the death of his wife.

The name of Dr. Carlos J. Finlay covers the history of medicine in Cuba throughout the last cen-

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tury. Dr. Finlay was a highly respected international authority on yellow fever. As a result of his long study of this dreadful disease, he announced at the International Sanitary Conference held in Washington, D.C., in February, 1881, that it was necessary to accept the existence of an intermediary agent to explain the "mysteries" of the transmission of yellow fever. This medical concept was totally new at the time.

Months afterwards, on August 14, 1881, he presented to the Academia de Ciencias de la Habana his experimental conclusions that the mosquito *Culex* was the only agent-transmitter of this disease. This mosquito is also known by the names of *Aedes aegypti* and *Stegomyia fasciata*. Dr. Finlay's paper to the Academia was translated by Dr. Rudolph Matas and published in the "The Mississippi Doctor" in February, 1882.

During the twenty years interim between the discovery and its probe by the Reed Commission, Dr. Finlay, an extraordinary linguist, published in different countries about forty articles on the topic which may be read in libraries everywhere. We would mention and recommend reading *Yellow Fever; Its Transmission by Means of the Culex Mosquito*, American Journal of Medical Sciences, Vol. 92:1886.

At the eighth International Congress of Hygiene in Budapest, Hungary, held in September, 1894, Dr. Finlay presented the fundamentals of a program to eradicate yellow fever. Later, this program was applied by Dr. William C. Gorgas in Havana and Panama.

The Reed Commission dedicated a whole year to the study of the Sanarelli bacillus which had nothing to do with yellow fever, while all along more deaths were caused by yellow jack in the American army than had been caused by the Spaniards' bullets during the war.

These sad events gave rise in the United States to such severe criticism by public opinion that Dr. Reed was prompted to return to Washington. In his farewell visit to the governor general, Dr. Leonard Wood, the governor ordered Dr. Reed to start the immediate study of the "Theory of the Mosquito" which had been set aside by Dr. Reed and his men.

Complying with the governor's order, that same afternoon of August 1, 1900, the commission gathered in Dr. Finlay's home. Finlay gave Reed the *Culex* eggs nurtured by him through several generations, and held in isolation to avoid being contaminated. Finlay also gave Reed all the information compiled during a life dedicated to scientific

observation and experimentation and cautioned the commission of the extreme danger of uncontrolled experiments.

A painting of this historic event appears on the front cover of the issue of December 12, 1966, of the Journal of the American Medical Association, and we can also read an editorial on this subject on page 1210 of this issue of JAMA.

On that same night of August 1, 1900, Dr. Reed returned to the United States on the S. S. Mascotte after ordering the members of the commission, Dr. James Carroll, Dr. Jesse Lazear and Dr. Aristides Agramonte, to study Finlay's theory.

Some days later an impressive telegram made Dr. Reed decide on his immediate return to Havana. Dr. Lazear lay dead due to the bite of an infected mosquito and Dr. Carroll gravely ill of an attack of experimentally produced yellow fever; the sequels of which caused his death one year later. These heroes of medicine proved to the world Finlay's truth. At last, Finlay's investigations had found



Carlos Juan Finlay, M.D. (1833-1915)

a possible cause of the extinction of the Mayan civilization, the xecxic.

During a banquet organized and presided at by Governor Wood in honor of Finlay, he presented to him a diploma and a Greek statue with the inscription, "To The Victor."

At the head of the table were the members of the Reed Commission to whom was accredited the merit of probing the Finlay discovery. Walter Reed never tried to appropriate to himself Finlay's discovery. In a preliminary note about his work in Havana, at the meeting of the American Public Health Association in Indianapolis, 1900, Reed said: "We here desire to express our sincere thanks to Dr. Finlay, who accorded us a most courteous interview and has gladly placed at our disposal his several publications relating to yellow fever during the past 19 years; and also for ova of the variety of mosquito with which he had made his several inoculations. With the mosquitoes thus obtained, we have been able to conduct our experiments. Specimens of this mosquito forwarded to Mr. L. A. Howard, Entomologist, Department of Agriculture, Washington, D. C., were kindly identified as *Culex Fasciatus*, Fabr. THE MOSQUITO SERVES AS THE INTERMEDIATE HOST FOR THE PARASITE OF YELLOW FEVER, AND IT IS HIGHLY PROBABLE THAT THE DISEASE IS ONLY PROPAGATED THROUGH THE BITE OF THIS INSECT."

In the official report by the American Government of Intervention in Cuba, published in the Congressional Record of 1902, one may read this statement written by General Wood: "The probing of the theory of the transmission of yellow fever, sustained by Dr. Finlay since 1881, justifies by itself the Spanish-American War."

The Institute of Tropical Medicine in Liverpool under the direction of Sir Ronald Ross, awarded Dr. Carlos J. Finlay its Mary Kingsley Medal. France decorated him with the Legion of Honor and a score of countries have honored his name on plazas and streets as well as monuments erected in his honor. Many biographical books and hundreds of articles have been published in different languages. Of

great interest is: "Finlay, the Forgotten Pasteur of the Americans" — Readers Digest.

On the centennial of this great scientist's birth, the Academia of Medicine of Paris and Hamburg paid tribute to his discovery. The Congress of History of Medicine in Madrid and Rome proclaimed his deeds. The Commemoration Festivities of his Alma Mater, the Jefferson Medical College of Philadelphia, were dedicated to his memory. The Congress of the Pan American Association of Medicine held in Dallas, Texas, agreed unanimously to dedicate the day of Finlay's birth, December 3rd, as the "Day of Medicine of the Americans." The eminent dean of the school of medicine of Tulane University, Dr. Rudolph Matas, brought to Havana a gold plaque with an inscription of gratitude from the city of New Orleans for the benefits received through Finlay's discovery. The Congress of the United States of America dedicated a special session to his memory in which the Representative for New York, Mr. Sol Bloom, proclaimed him "The Liberator of the Tropics."

In one of the conclusions of the laboratory report by the Reed Commission the following sentence appears: "The serum of persons infected with yellow fever, passed through the finest Berkefeld filter and injected into a nonimmune, produced a typical yellow fever."

This was the first time that a filtrable virus was mentioned in human medicine. Sad irony of destiny! Neither the historians nor the members of the commission realized the enormity of their subtle findings and twenty years later the credit was given to Noguchi, leaving to total oblivion the brilliant work of Reed and his men.

We believe that great benefactors of humanity should not be ignored. We should take a step forward to face injustices which are, generally, the cause of misunderstanding nations. To this effect, please, read Mr. D. C. Corbitt's observation in the A.M.A. News, issue of March 22, 1965.

Dr. Guiteras said: "On the victory over yellow jack there is glory for the discoverer and for the heroic verifiers. Why not place each one in the proper historic echelon achieved?"

Historical Review of Cuban Pediatrics

Jorge J. Beato, M.D.



Dr. Beato

impossible to talk about one without referring to the others. All effort, therefore, for historical purposes of Cuban pediatrics, should be carried out parallel upon the development of both sciences, at least at the initial stages.

From a medical point of view, since the early part of the colony there was lack of everything. In Cuba, there was no faculty . . . or very few; most preferred to find in the marvelous kingdoms of Mexico and Peru the gold which was lacking in the island. This extreme lack of doctors compelled the early population to depend on "outsiders" to cure them or console them in their illnesses, and it's here that there appears in our midst one of the old figures of medical art, the midwife. Aid in childbirth was practically in their hands, but the majority were ignorant and inexperienced and performed badly. In 1824 the medical tribunal made an effort to regulate the art of delivering children, naming Dr. Domingo Rosainz, responsible for the formulation of a book or text to better the knowledge of the midwives and to serve as a guide during examinations to obtain the corresponding certificate for practicing. Domingo Rosainz (1797-1855) was one of the first great Cuban obstetricians (for his expertise and ability he was known as the Cuban "Maigrier"). He published his work in December,

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Pediatrics, as a specialized field of medicine, did not really exist among us until the third part of the nineteenth century. Until then, in Cuba, as well as in many other parts of the world the study of childbirth and the illnesses of women and children were so intimately bound, that it is

1824, and according to authoritative opinions his work was the first on obstetrics published in Cuba. (Fig. 1).

The appearance of the "text", aside from its elemental character, created major interest among doctors and students of medicine, instead of among the midwives, to whom it was especially directed. The lack of texts on obstetrics, and the lack of special courses within this field at the University of Havana, made this text serve as a stimulus for other professors to offer extracurricular courses dealing with the art of childbirth. Francisco Alonso Fernandez (1797-1845) from Puerto de Santa Maria, Spain, was the first in Cuba to offer a complete

EXAMEN Y CARTILLA

DE PARTERAS,

TEORICO PRACTICA,

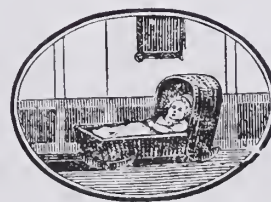
ESCRITA

POR EL DR. D. DOMINGO ROSAINZ

MEDICO, CIRUJANO Y COMADRON, FISCAL DE PARTERAS,

SOCIO NUMERARIO DE LA REAL SOCIEDAD PATRIOTICA Y

MIEMBRO DE LA JUNTA DE VACUNA.



(Con superior permiso.)

En la Oficina de Don José Boloña, impresor de la Real Marina, calle de la Obra-pía númº 37.

1824.

Fig. 1 — The first Cuban publication on obstetrics. It includes a chapter devoted to the fetus and the newborn.

course concerning this subject. It started on May 16, 1825, at the Military Hospital at San Ambrosio, and lasted five months. Its subject matter comprised questions dealing not only relative to the mother but also the fetus and the illnesses of infants and was published in a small brochure unavailable today, but which Cowley reproduced in his well known works on the teaching of medicine in Cuba. In the same year of 1825, the Cuban, Tomas Montes De Oca (1776-1831), the most renown surgeon of his time, carried out the first cesarean operation in our country.

This series of events created the necessary conditions for the founding of the Academy of Midwives, through the personal direction of Rosainz and with the backing of the Bishop of Havana, Espada. This academy was inaugurated on June 7, 1825, at the old Hospital of San Francisco de Paula.

Prior to these efforts, the Cradle Home (Casa Cuna), projected by Bishop Compostela, and founded by his successor Bishop Geronimo Valdes in 1710 had been the only institution dedicated to the foundlings. It was transformed in 1832 as the Royal Maternity Home (Real Casa de Maternidad), through the efforts of Father Marianao Arango and under the protection of Bishop Espada. It was first located at the corner of Prado and Trocadero, and then after various places, and finally wound up at the San Isidro Orphanage, located on the same street name between Picota and Compostela. Rosainz was the doctor at the Royal Maternity Home who aspired to establish in it a school of childbirth and illnesses of children, which would serve as a learning experience for students of medicine; however, he was unable to carry out his goal. The Cuban, Juan Jose De Hevia (1795-1878), who succeeded Rosainz, was a tremendous observer and had an exceptional ability for teaching. He later published his experiences as a faculty member of the Royal Maternity Home in a small book entitled, "Treatise of the Illnesses of Children and How to Cure Them," which was the first published in Cuba concerning pediatrics. (Fig. 2). We regret that the lack of space restrains us from commenting more about this work. It constitutes an authentic testimony of the personal experiences of the author, who limited himself to his own personal points of view concerning the illnesses of infants whom he personally dealt with, without the habitual references to foreign authors, which was the custom at the time.

But the real impetus concerning the study of pediatrics and obstetrics came with the creation of

TRATADO

DE LAS

ENFERMEDADES DE LOS NIÑOS

MODO DE CURARLAS

POR EL DOCTOR

DON JUAN JOSE DE HEVIA,

SEGUNDO AYUDANTE DEL CUERPO DE SANIDAD MILITAR DEL EJERCITO, CONDECORADO POR S. M. CON LA CRUZ DE EFIDEMIA, FACULTATIVO DEL CASTILLO DEL MORRO, MEDICO, CIRUJANO Y COMANDANTE DE LA CASA DE MATERNIDAD Y HOSPITAL DE SAN LAZARO, AUXILIAR DE MEDICINA Y CIRUJIA DE LA CASA DE BENEFICENCIA Y HOSPITAL DE SAN JUAN DE DIOS, INDIVIDUO DE NUMERO DE LA REAL SOCIEDAD ECONOMICA Y MIEMBRO DE LAS SECCIONES DE EDUCACION, AGRICULTURA Y COMERCIO DE LA HABANA.

HABANA.

Imprenta del Gobierno y Capitanía General por M. M.

1845.

Fig. 2—The first Cuban publication on pediatrics.

the corresponding school at Havana University in 1842. In that year a deep and profound transformation of university life and the character of teaching was realized when the old Pontifical University was secularized and became the Royal Literary University. Among the new courses created for the school of medicine was that of "Obstetrics and Illnesses of Women and Children." Named professor of this course was Dr. Joaquin Guarro (1807-1881), Catalan, born at Capellades and graduated in Madrid, who had studied medicine in Paris and Montpellier. Besides the theoretical courses he taught at the Santo Domingo Convent, Guarro organized practical classes in the Royal Maternity Home, situated at the time in the San Isidro Orphanage. (Fig. 3). Therefore, he was the first in Cuba to teach those disciplines as a university professor.

In 1849, Guarro resigned as a professor and returned to Spain. His successor, Dr. Isidro Sanchez Rodriguez (-1859), from Chiclana near Cadiz, formulated a curriculum of each of the disciplines, including courses in the illnesses of infants. This

document called "Infants Diseases Program" (Programa de las Enfermedades Infantiles) is the oldest found concerning the teachings of pediatrics in our country. It imparts to us the knowledge relating to the infant, especially the newly born, which the graduates had at that time. Generally speaking, the program was not the best, and in reality demonstrated what the teachings of pediatrics was really like at the time, a simple supplement of the study of obstetrics.

But already at the beginning of the second half of the nineteenth century it is evident that the study and treatment of the illnesses of infants as a field of medicine which required specialization was under consideration. The education of Cuban doctors concerning this subject was accomplished through Spanish versions of French pediatric texts. First the treatise of Jose Capuron, and the classics of Bouchout, Rilliet and Barthez, were for many years the required texts. It was precisely a Frenchman who came to Havana, Julio Jacinto Leriverand, Professor of Physiology, Pathology and Personal Hygiene at the University, to whom we owe the first scientific work on lactation. His (*Memoria sobre la Leche*) "Memory on Milk" published in Havana in 1849, is the first published in Cuba on this subject.

From France also came the publications on pediatrics by Cubans in a foreign country. Federico Echarte, from Havana, presented a doctoral dissertation in medicine at the school of Paris on "Children with Eclampsia," and later Esteban Llorach, from Matanzas, published a thesis entitled, "Considerations on Hygiene at the Beginning of Infancy." Little by little the trends of French science of the time were felt in our midst. Already in 1877, a Cuban, Rafael Alvarado y Bauza, in the solemn act of receiving his doctorate from the School of Medicine of the University of Havana presented a work on "Hygiene of the First Day of Life," which constituted the first contribution to the literature on perinatology.

In the decade of the 80's, precisely in 1887, pediatrics obtained the category of specialized knowledge, separating itself completely from the studies of obstetrics and gynecology. Through a Royal Decree of July 28, 1887, a series of reforms were introduced into the curriculum at the School of Medicine of the University of Havana, and among them a "Special Course on the Illnesses of Infancy with its Clinic."

The first professor Dr. Tomas Plasencia y Lizaso (1840-1894) from Limonar, Matanzas, tried in vain to find a place for practical teaching of the

course, but had to content himself with only theoretical materials during the four years he taught the course. He was succeeded by Dr. Antonio Jover y Puig (1860-1930), born in Barcelona, who won the course despite great opposition from Dr. Joaquin Duenas, in 1891. His teachings, as in the case of Dr. Plasencia, were merely theoretical. The difficulty he encountered in finding an appropriate clinic for practical teaching was the subject of one of the most brilliant lectures he presented when he took over the professorship. He entitled this lecture, "The Concept of Pediatrics and its Corresponding Place in Teaching." For the first time in our medical history the specialty was designated with its modern denomination. Dr. Jover was also responsible for the first text on the subject which was published in Barcelona in 1893. (Fig. 4).

Upon the end of Spanish sovereignty, Dr. Jover resigned and was succeeded by Dr. Jose Rafael Montalvo y Covarrubias (1843-1901), who taught the subject during the period of the American intervention. He was the fortunate one who inaugurated the practical teaching clinic on the subject and who resided at Nuestra Senora de las Mercedes Hospital. (Fig. 5). His tenure of the professorship unfortunately was of short duration because he died only two years after taking over the position.



Fig. 3 — This ancient house in The Old Havana section (on San Isidro Street between Picota and Compostela) was the Royal Maternity Home. Here were given the first practical lessons in obstetrics and pediatrics about 1843. Toward the end of the nineteenth century the Faculty of Medicine of the University of Havana was located here.

Subsequent to the implementation of the so called Plan Varona in 1900, which was mostly for economic reasons instead of academic motives, the professorship of Pathology and Infants Clinics remained part of the Medical Clinic. Designated to carry it out was Dr. Cecilio Reol y Ferrera (1851-1906) from Guanajay, Pinar del Rio, but as with Montalvo, his stay was short; he died on May 25, 1906.

At the closing of this review of the colonial period of Cuban pediatrics, four figures, although not closely bound to the professorship, cannot be ignored. We are referring to Dr. Joaquin Duenas y Pinto (1859-1910) who was the first Cuban doctor to become in the modern terminology a pediatrician. He enriched our pediatrics literature with valuable works such as, "Contribution to the Study of Primitive Chronic Enterocolitis During Early Infancy," an important study, read in English at the Pan-American Medical Congress held in Washington in 1893. His best scientific work, entitled, "The Illness of Barlow in Cuba," was published in Havana in 1905. His scientific reputation reached high international status when in 1907 he was selected to develop the chapters on Dengue y Muermo, of the Phaundler and Schlossman Pediatric Encyclopedia.

Another of the brilliant figures during the end of the century on pediatrics was Dr. Domingo L. Madan (1856-1898), born in Matanzas and graduated from the University of Havana in 1878, and to whom we owe the first dispensary for poor infants in Cuba. This was inaugurated in his own home town on September 2, 1894. Manuel Delfin y Zamora (1849-1921) was another pioneer of Cuban pediatrics, and although he did not practice the specialty as did Duenas y Madan, his name has to be remembered because he did associate himself with the first works of assistance for infants in Cuba. And last but not least, Gonzalo Arostegui del Castillo (1859-1940) who dedicated more than 40 years of daily service to the Home of Benevolence in Havana; and Luis Ros, a distinguished doctor from Cardenas, to whom we owe in 1895 the first book of popular information concerning maternal and infant problems which was entitled "Practical Guidance for the Mother." (Cardenas, publisher: La Concha de Venus, 1895).

At the beginning of the Republic, in 1902, the Cubans were faced with a difficult and complex task. Aside from all the problems confronting them upon the change of regime, were added all those that resulted as a consequence of a nation devastated by a war for more than three years. One of the most

pressing problems was that of sanitation in Cuba. This related to the major epidemics that hit the island, (yellow fever, typhoid fever, malaria, small-pox, and the high mortality rate among infants) and were attacked with vigor and solved as they appeared. Perhaps the most significant effort was the campaign against yellow fever.

The diminishing of the infant mortality rate from its high figures at the outset of the century to one of the lowest in Latin America up until the 50's, was not the task of one man nor of one public administration. To it many contributed, in a major or small way, and many governments of the Republic. These efforts resulted in the services of infant hygiene, created through the initiative of Enrique Nunez during the government of President Menocal; the maternity hospitals, founded during the administration of President Machado, and the National Organization of Infant Dispensaries promoted by President Batista.

During these tasks, the physician contribution was considerable. The professional contribution of

LECCIONES DE ENFERMEDADES DE LOS NIÑOS

PROFESADAS EN LA

UNIVERSIDAD DE LA HABANA

POR EL

DR. D. ANTONIO JOVER

Catedrático, por oposición,
de dicha asignatura, Médico Cirujano de la Facultad de Londres,
Director de la casa de salud «Quinta del Rey», etc.



BARCELONA.—1893

IMPRENTA DE HENRICH Y COMPAÑIA EN COMANDITA
SUCESORES DE N. RAMIREZ Y COMPAÑIA
Paseo de Escudellers, 4

Fig. 4 — The first Cuban text of pediatrics.

the Cuban pediatricians was carried out through three fundamental institutions: the School of Pediatrics at the University of Havana, Cuban Society of Pediatrics and the Municipal Hospital for Infants in Havana.

The Professorship of Pediatrics, which was left in 1906 as an annex to the Medical Clinic, was now directed by a man who is considered for many reasons the founder of the school of pediatrics in Cuba, Angel Arturo Aballi Arellano. (Fig. 6.) He was born in Matanzas on September 30, 1880, and died in Havana on July 23, 1952. He was the creator and orientator of nearly all the pediatric institutions in Cuba. His teaching task extended for almost half a century. Aballi was one of those professors who knew how to produce students in quantity and quality, first because of the need to help his school survive, and then to take it to the highest place of excellence. Although it is dangerous to cite names, for lack of doing justice, but perhaps the first generation of pediatricians would be represented by Jose Jordan Avendano, at Pinar del Rio; Miguel A. Beato, at Matanzas; Agustin Anido, in Las Villas; Oscar Ortiz Machado, Camaguey; and Antonio Beguez Cesar, in Oriente.

In 1923, the Professorship became independent of the Medical Clinic and acquired its own individuality under the name of "Pathology and Infants Clinic." Collaborating with Professor Aballi, was Professor Felix Hurtado Galtes, who succeeded him, and Professors Teodosio Valledor Campos, Agustin Castellanos Gonzalez and Arturo Aballi Garcia-Montes, with a select group of appointees and instructors among whom I recall Gustavo Cardelle, Gustavo Garcia-Montes, Roberto Valdes Diaz, Gabriel Gomez Del Rio, Serafin Falcon, Carlo Hernandez-Mivares, Mario Fernandez Alonso, Alberto Mata Lavin, Rene Montero, Emilio Soto Pradera, Julio Cabrera Calderin, etc.

The formative period of Cuban pediatrics finished in 1928 with the establishment of the Cuban Society of Pediatrics. By then there were enough young specialists fully qualified to become scientifically independent, and this society came into being, through the initiative of Hurtado, and in memory of Professor Aballi. A year later, in 1929, a bulletin was published, the official organ of the society. This was later transformed into the **Cuban Pediatrics Magazine**, which appeared uninterruptedly for over 30 years until its disappearance in 1959 with the coming of Castro-Communism.

The society from its beginning projected itself into the interior of the Republic with the objective of



Fig. 5 — The old hospital, "Our Lady of Mercedes," as it appeared in 1930. It was founded in 1886 and demolished in 1958. In its wards the clinical teaching of pediatrics was initiated in a regular manner.



Fig. 6 — Professor Angel Arturo Aballi (1880-1952). Professor of Pediatrics at the University of Havana (1906-1948) and founder of the Cuban school of pediatrics.

taking specialized knowledge to the great number of doctors throughout the Republic, who without being pediatricians, still attended a great number of children. This way twelve reunions were held regularly which were called Pediatric Journeys. Later came courses like "Therapeutics of Illnesses of Infancy," which hundreds of doctors attended yearly from all over the country.

From the international aspect, Cuban pediatrics was recognized for two famous triumphs, thanks to the efforts of its delegate, Professor Felix Hurtado. At the Fourth International Congress of Pediatrics celebrated in Rome in 1937, a motion was approved that the Spanish language be officially recognized at the Congress. The old desire of uniting the Latin American pediatricians had in Hurtado a definite supporter and thanks to his friendly ties to three great American pediatricians, Drs. Clifford Grulee, Frederick Schultz and Henry Helmholtz, the American Academy of Pediatrics modified its statutes of 1942 with the object of admitting as a fifth region (later ninth) the Latin American pediatricians. The Cuban branch was immediately formed and developed its activities uninterruptedly until 1959.

Now we come, at last, to the Municipal Infancy Hospital of Havana, which was one of the most notable centers of infant assistance in Cuba. It would be proper to mention other similar institutions, like the services for children from the School of Pediatrics of Mercedes Hospital, directed by Professors Valledor and Hurtado; the University Hospital managed by Professor Clemente Inclan; the childrens clinic of the Hospital of Workers Maternity, and the service for the newly born of the American Arias Maternity Hospital directed by Dr. Serafin Falcon. But perhaps none had such a major influence in the formation of Cuban pediatricians and the development of the specialty, as did the Infant Hospital in Havana. It was constructed during the municipal government of Dr. Miguel Mariano Gomez, thanks to the fortunate initiative of Professor Aballi. It began to function while Dr. Guillermo Belt was mayor of Havana in 1935. Besides its purely patient care aspects, developed through external consultations, and more than 300 beds for hospitalization, the hospital de-

veloped an intense research program and at the same time gave preferential attention to the teaching of pediatrics.

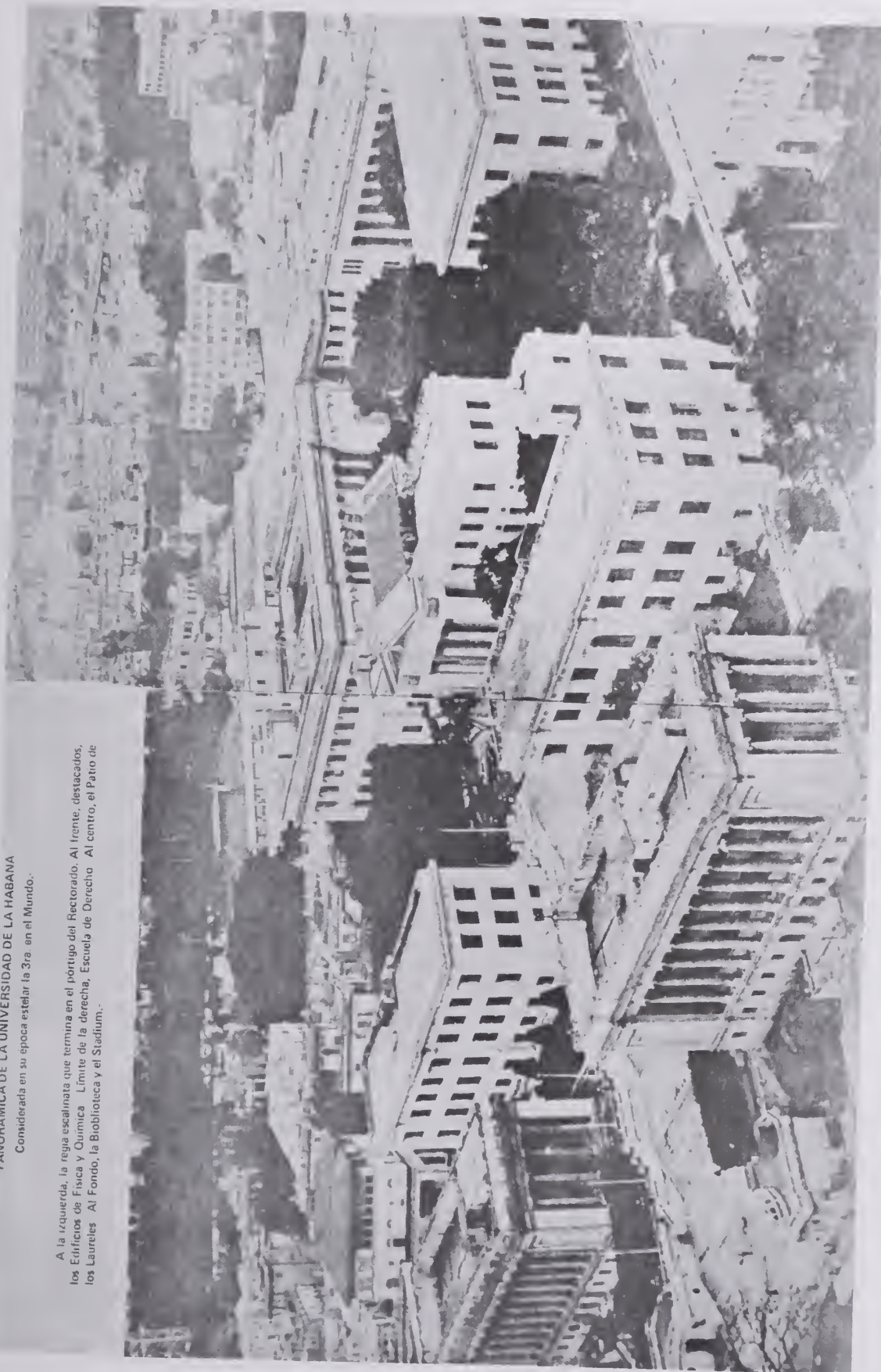
A good number of Cuban pediatricians carried out their scientific and clinical duties at the Infant Hospital at Havana. In some of its rooms cardiologic investigations were carried on by Professor Castellanos, a world pioneer of angiocardiology studies. There were also the bacteriological contributions effected by Professor Curbelo and Martinez Cruz who came up with the discovery of the Havana Salmonella, the studies on virus and rickettsias of Juan Embil, and the investigations concerning Vitamin A and its relationship with lipoidosis of Professor Castellanos and this humble servant.

Within the hospital was the Castellanos Foundation, the first institution for medical investigations organized in Cuba through the intellectual and economic efforts of a private doctor. Located also within the Infant Hospital in Havana were the Neuro-Pediatric Institute, the Municipal Center for Prematures and the municipal services of Cardiology and Orthopedics.

Cuban pediatrics had its leading role in 1953 with the celebration of the VII International Congress of the specialty. Six years later this ascending march was interrupted by the coming of Castro-Communism. Ninety-five percent (95%) of the Cuban pediatricians, many to save their lives or wanting to continue the freedom denied in their own land, preferred exile in this generous American land. We have worked and have arduously studied; some as professors, investigators and lecturers occupying important academic positions in universities. Perhaps the most significant recognition of Cuban pediatrics came when our great friend, Dr. E. H. Christopherson, Director of the American Academy of Pediatrics from 1958 to 1967, obtained through the Executive Committee of that institution a decree to the effect that all the Cubans who were members of the Academy be automatically made members of the corresponding chapter in the United States, without an examination or selection of any kind. We shall never forget that gesture and we feel proud of this declaration.

PANORAMICA DE LA UNIVERSIDAD DE LA HABANA
 Considerada en su época estelar la 3ra. en el Mundo.

A la izquierda, la regia escalinata que termina en el pórtico del Rectorado. Al frente, destacados, los Edificios de Física y Química. Límite de la derecha, Escuela de Derecho. Al centro, el Patio de los Laureles. Al Fondo, la Biblioteca y el Stadium.



A panorama of the University of Havana.

Brief Recount of the History of Obstetrics and Gynecology in Cuba

Julio Ortiz Perez, M.D.



Dr. Perez

The history of Cuba prior to the Communist takeover is conveniently divided into two periods: the colonial period and the period of the republic. The colonial period reflected the culture of the colonizing nation, Spain. However, it was during this period that the great Cuban physician, Carlos J. Finlay, studied yellow fever and in 1881 first enunciated his theory of the role of insects in the transmission of yellow fever. During the period of the republic which began with the First American Intervention, Finlay's discoveries were put to practical use and ultimately yellow fever was eradicated. Public health and hygiene thus began in Cuba. The principles of hygiene and prophylaxis so emphasized by Finlay were equally applicable in obstetrics.

At this point let us introduce the pioneer of obstetrics in Cuba, Eusebio Hernandez Perez. He said of his life's dedication: "For as long as I've lived a responsible life, I haven't pursued another end than the good of my country."

With the failure of the so-called "Guerra Chiquita" and there being then nothing to do for the time being for the independence of Cuba, he went to France with the object of broadening his medical knowledge. Until well into the twentieth century that was the course that our doctors followed and the influence of the French medical school among us was always considerable. In Paris he found Adolfo Pinard, Professor of Obstetrics at the Faculty of Medicine, who first in the maternity of the Lariboisiere Hospital and then in his service of Baudelocque, was bringing obstetrics out from what we could call its Middle Age. There he worked

intensely among all that school that Pinard had created: Varnier, Potocki, Wallich and so many others, until the movement created by Marti made him return to the United States and then to the Cuban jungle. Varona's university reorganization made him titular Professor of Obstetrics. At the San Antonio ward of the Mercedes Hospital, he funded the Pinard Clinic and from there came all obstetricians in Cuba from 1900 until 1925. In the latter year he obtained for the school of medicine the maternity which was on Calixto Garcia Hospital grounds but until that moment had not made any contribution to the education of obstetrics in Cuba.

His education was objective and eminently practical. His aphorisms were easily retained by his pupils: "The duty of an obstetrician is for babies to be born at term and without traumatism." That aphorism was stated from the first years of this century. "The symphysiotomy is the real treatment of the pelvic angosties mild and light that the cesarean section leaves as they are."

He said that his teaching came from nature and went back to it. He considered symphysiotomy as one more step toward the pelvic enlargement that pregnancy produces by softening the sacroiliac joints and especially the symphysis of the pubis. He considered dystocia a lack of enlargement of the symphysis of the pubis and his concept about what he called "syndrome of cephalo-pelvic insufficiency" was repeated partially in what the Americans called years later "cephalo-pelvic disproportion."

All of Hernandez' work has an eminently prophylactic basis. In 1910, at that years National Medical Convention, he presented with the collaboration of his brightest student, Domingo Ramos, his admirable study about the evolution and culture of the human species, which he called Homiculture. All the stages of human life, governed by the reproductive cycle, influenced by heredity and old age considered as postgenital culture, were studied in that monument that Hernandez and Ramos had created and organized with such vision of the future,

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that even today, nearly 70 years later, every step of progress has a place in it, as if it could have been foreseen.

In 1923 the Law of the School of Medicine created the second professorship of obstetrics and Alberto Sanchez de Bustamante, who until then had been assistant professor was promoted to this professorship with every right. Sergio Garcia Mar-ruz and Jose Ramirez Olivella, also with every right were the assistant professors.

I saw Bustamante perform the first low segment cesarean section, that was done in Cuba. I also saw him perform the first cesarean by Portes method that was practiced in this hemisphere. When dystocia came forth, the cases were already infected and against the septic element our defenselessness was complete. That made Schikale in Strasbourg import in France, after World War I, the cesarean on the inferior segment of the uterus, which the Germans had already been using for several years.

In 1923 Louis Portes, the chief of Baudelocque's clinic, practiced the cesarean with temporary exteriorization of the uterus, then a few weeks later, when the infection had been arrested, it was restored to the abdominal cavity. A few months later Bustamante practiced it for the first time in this hemisphere with great success.

In the late twenties, Emilio Yero Bou, used for the first time in Cuba, magnesium sulphate in 50% solution, 10 mg. in each buttock against the hyperreflexia and convulsions of eclampsia. If it was not the first time in the world, it was at least one of the first.

One of the facts that marks an era in the history of obstetrics and gynecology in Cuba, was the creation of the Municipal Maternity of Havana and that was the work of the then assistant professor Jose Ramirez Olivella.

The educational task of that maternity was incalculable. It permitted the Cuban obstetrician to feel truly an obstetrician-gynecologist and to have an ample surgical training. In 1921 at that years National Medical Convention, Olivella was in charge of obstetrics and it dealt with the treatment of eclampsia. It was the first time that arterial hypertension in eclampsia was discussed thoroughly.

In 1937 Olivella founded the Cuban Society of Obstetrics and Gynecology which thanks to the feat of the Cuban obstetricians and gynecologists, has lasted in exile with great splendor. The conventions were biennial and they were soon honored by the attendance of distinguished foreign colleagues:

Meigs from Harvard, Greenhill from Chicago, Robert Gordon Douglas from New York, TeLinde and Eastman from Johns Hopkins, Alvarez-Bravo, Guerrero, Furnier, Ayala and Valdes Lavallina from Mexico, Watteville from Geneva, Maurice Mayer, Lamaze and Thierry from Paris, Murray from Argentina, Campos Dapaz from Brazil, Diaz Bazan from El Salvador, Noel and Aguero from Venezuela and Caldeiro Barcia from Uruguay.

The first convention of the Cuban Society of Obstetrics and Gynecology was held under the presidency of Dr. Gonzalo Arostegui.

In 1953 The South Atlantic Association of Obstetricians and Gynecologists held their annual Convention in Havana and the Cuban Society of Obstetrics and Gynecology was invited to take part in it. The society presented the program on gynecology and let us have obstetrics asking us for some local "flavor." That took place 24 years ago and our society presented them a session called "Symphysiotomy Versus Difficult Forceps" which dealt with the possibility of having a little more room in the pelvis when needed. The wife of a medical colleague who had had a symphysiotomy operation a few weeks earlier offered to walk before the audience. They agreed that the operation was effective, but asked: "How can the training be obtained?" That year, and for the first time in the history of our society, the memoirs of the convention were published. That was due exclusively to the courage and irrevocable will of Juan Antonio Rodriguez Feo, who in that biennial was the general secretary of the society, with the collaboration of the recording and corresponding secretaries, Eduardo Diaz Betancourt and Alberto Diaz Salazar. Two years later, Tomas Armstrong as president and Hector Rocamora as secretary held the First International Assembly of Obstetrics and Gynecology. The memoirs were also published and that way remained for the future what should be considered in every sense the greatest manifestation of our obstetrics and gynecology.

In 1954 the Cuban Society of Obstetrics and Gynecology was invited to the Constitutional Convention of the International Federation of Gynecology and Obstetrics. (FIGO) It was held in Geneva. We were entrusted with a report about "Prophylaxis of the Obstetric Traumatism in the Fetus." The session was presided over by Pierre Lantuejoul, Professor of Obstetrics at the Faculty of Medicine in Paris and a friend of Juan Blanco Herrera. It was published in the memoirs of the convention.

Hubert de Watteville, first president of the federation was later in Havana and gave us two lectures

at the Municipal Maternity, Havana's "Maternidad Obrera" founded in 1941. This the youngest of our big obstetric centers, was a center of research and contributed extensively to the training of numerous colleagues; the obstetrics practiced there was of the highest quality.

I have expressly decided to leave for the end three important events:

First, the book published by Hernandez in the year 1922: "Critical History of Pelvitomy." That obstetric operation definitely belongs to history, but if anyone wants to recall it, he would have to refer to that book.

Second, the text on obstetrics published by Ramirez Olivella in 1935. Among those who collaborated, Mariano Diaz who was associate professor of obstetrics and who worked in the preparation of that book with extraordinary energy, stood out, as well as Rocamora, Tabares, Benach all of whom were assistant or associate professors of obstetrics. All those who contributed to that book can be very satisfied because the work that was accomplished was highly honorable. It was the only text published during the stage of the Republic.

Third, the works of Juan Antonio Rodriguez Feo at the Maternity Department of Calixto Garcia Hospital: a) Detection and Measurement of Chorionic Gonadotropin. This began in the early thirties with the Adela Brohua test in the isolated rabbit. It first served for the early diagnosis of pregnancy and later when the Brindeau units showed up and the titration of chorionic gonadotropin could be performed, for the early diagnosis of the hydatidiform mole and its follow up postevacuation of the mole with the object of early diagnosis of its most feared complication the chorioepithelioma. b) Amniocentesis. This began in the early forties. The placenta was located by means of "soft x-rays." If placental insertion in the anterior wall of the uterus was not detected, amniotic puncture was carried out through the abdominal wall and anterior wall of the uterus. This procedure was used to detect meconial amniotic fluid at the end of pregnancy or during early labor with intact membranes.

The amnioscope which appeared years later was not known. It was also used to detect dark red

amniotic fluid in cases of fetal death during pregnancy which resulted in vesiculation of the skin and maceration.

It was also used in cases of polyhydramnios to reduce intrauterine pressure produced by the excess of amniotic fluid. In these cases it was repeated several times. In those times the possibility of prenatal diagnosis wasn't known and, of course, it wasn't practiced if by x-ray some fetal anomaly could be diagnosed like anencephalia or hydrocephalia or some cases of bifid spine. c) X-ray of hydatidiform mole. In cases in which the diagnosis of the mole needed to be corroborated, the uterus was punctured. If there was no amniotic fluid one was assured that there was a mole and then injected the uterine cavity with an aqueous contrast media and at once obtained an x-ray.

I had the privilege of being present at the first demonstration and to take part in the emotion of all of us who saw that x-ray. It was unique. A few days later I came across Dr. Rafael Gomez Zaldivar who wasn't aware of anything. I presented him with the x-ray and asked him: "What do you think this is?" He looked at the x-ray thoroughly and answered: "The x-ray of a sponge."

In June, 1959, the annual convention of the American Medical Association was held in Miami and possibly because of the American curiosity for seeing what was going on in Cuba, they had a post-convention session in Havana. It was the beginning of the misfortunes of our land, we were still at the stage of lies and the "Colegio Medico Nacional" still existed. It took part in the post-convention session and there Rodriguez Feo's x-rays were presented although he had lamentably passed away a few months before. Everyone said they had not heard of the procedure and never seen x-rays of that kind.

I am grateful to Enrique Huertas for entrusting me this "Brief Recount of the History of Obstetrics and Gynecology in Cuba." I have written it with the same good faith and love of truth with which I have always lived. I apologize for any omissions. Those which I have committed were involuntary. I didn't have any other form of information than my mind, my heart and my father's memory. He and his brother Octavio were premedical students at the University of Havana when in 1871 the killing of the students of the first year of medicine took place. His father sent them to France and there they graduated in 1881. My life has been easy, because the only thing I've had to do is follow his example.

The "General Calixto Garcia" Hospital Its History

J. C. Gros, M.D.



Dr. Gros

The University of Havana had two hospitals for the teaching of the medical students: the General Calixto Garcia and the Queen Mercedes hospitals. The General Calixto Garcia was larger and had more beds. It was named to honor the memory of a distinguished general in the war which started in

1868 to liberate Cuba from Spain, following the independence movement of all the countries of the American continent. General Garcia was very well known; he had been the receiver of the famous "Message to Garcia," a popularized episode of the Cuban-American-Spanish War.

The construction, organization, and development of this hospital took several years. The first structures were built in 1913 while General Mario Menocal was the president of the Republic and Dr. Enrique Nunez his health secretary; but still in 1958, when unfortunately there was a radical change in the political system of government in Cuba, the now autonomous University of Havana through its medical faculty was always trying to construct new buildings and improve the departments already functioning.

They had enough room because the General Calixto Garcia was built step by step in the great space occupied by the "Number One" Hospital, inherited by the Cuban Republic from the First American Intervention government, which provisionally ruled the country in 1898 after the Spanish dictatorship. This big area was located in the Vedado suburb between University Avenue and 25th Street and between J and G Streets behind the University of Havana.

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The old Number One Hospital was a series of one story wooden buildings, many of them connected by covered corridors and separated by gardens. These wooden buildings were doomed to be demolished; the first ones to be torn down were those lodging the internal medicine and surgical patients who were moved to the new buildings. Even in 1921 still in service were two wards for mental patients, the Munoz and Valdes Anciano; one ward, the Cueto, for minor surgery in males; one for gynecology, the Primelles ward; one ward for the veterans of the independence war; the Miss O'Donnell ward for the nurses, and four wards for advanced cancer and diseases considered incurable, the Luaces ward. Luaces ward was named for a rebel Cuban physician, Dr. Antonio Luaces, who was made prisoner by the Spaniards during the first years of the independence war and killed by his captors for his gallant attitude during the trial.

Behind the Number One Hospital, on the west side of G Street there was another wooden hospital which was for tuberculosis patients, the Romay Hospital, named to honor the memory of Dr. Tomas Romay who introduced the smallpox vaccine in Cuba at the same time that Edward Jenner was doing it in England. The Romay and the Number One were connected by a wooden bridge crossing above G Street, in those days a wide thoroughfare without any buildings on its east or west sides. This hospital was used by Dr. Federico Grande-Rossi, then Professor of General Pathology, to teach his students auscultation of the lungs.

The first new buildings, properly representing the new hospital, began to admit patients as soon as they were finished. The first row of buildings was facing University Avenue. From N.E. to S.W. there was a big auditorium to be used for lectures; its upper story at the beginning housed the Medical Alumni Association. Next was the Administration Building with the director and administrator offices, and with rooms for the interns and students. Medical students obtained this position in the fourth and fifth years of their studies, and were selected

according to scholastic standing. The third building was for the nurses, and for the Nurses School; it lodged the registered nurses who worked in the hospital and the nurse students; their teachers ordinarily were from the hospital staff. The next building was an outpatient clinic where the departments of urology, ophthalmology, otolaryngology and dermatology kept different sections for consultation and treatment of their patients. There was a dental clinic too, a small x-ray department, and a small operating room. In this operating room during January 1923, Dr. Emilio Martinez, chairman at that time of the department of otolaryngology, performed the first total laryngectomy in Cuba under local anesthesia; and finally, at the end there was a comfortable house to be used by the director of the hospital as his residence.

Behind this first row and separated by well paved streets was built a true hospital city. The General Calixto Garcia had been planned following the model of the Virchow Hospital in Berlin, where each department had its own building. During the first quarter of the century this pattern was accepted as the ideal for the best treatment of patients.

The second row of buildings began with the radiology department with Dr. Pedro L. Farinas as chairman; with the passing years Dr. Farinas became a highly esteemed member of the Cuban Medical Federation and a most distinguished radiologist; his contributions appeared in the Radiology Journal and in other scientific publications in Europe and the U.S.A. Next, there was the emergency department; it was a one story building named "Cubas" honoring the memory of Dr. Domingo Cubas, a professor of the medical school who played a gallant role in 1871 during the trial of a group of innocent medical students who were executed by the Spanish government. This department had wards for males and females, two physicians were on duty for 24 hours, one for the admission of emergencies coming from outside, and the other for the emergencies occurring in the hospital; each physician had an intern as assistant. There was an operating room to be used in emergencies after 6:00 p.m. It was in a small room of this building in 1922 where a fifth year medical student, Nicolas Puente Duany, by his own effort created the first laboratory of pathology in the hospital. This student later became the Professor of Pathology. The next building in this row had two stories; the ground floor was the San Martin ward for gynecology; the chairman was Dr. Manuel Costales Latatu, an elegant and

skillful surgeon who later would be Professor of Surgery and Education Secretary of the Republic. The upper floor was the Enrique Lopez ward, shared by the Department of Ophthalmology with Dr. Jorge L. Dehogues as chairman, and the Department of Otolaryngology with Dr. Emilio Martinez as chairman, who later would be Dean of the Medical School and Health Secretary of the Republic. These two departments admitted patients needing surgery or special medical treatments from the outpatient clinic. The next building in this row had the Cabrera Saavedra-Jacobsen ward on the ground floor which received patients with medical diseases. The upper floor was the Albertini ward for children in charge of Dr. Clemente Inclan, a well known pediatrician who later became Rector of the University of Havana.

The third row of buildings began with the pharmacy on the ground floor and the general laboratory on the upper floor; chairman of the pharmacy and laboratory was Dr. Cesar Fuentes. To the west there was the Central Surgical Department where surgery was performed on the patients admitted to the surgery wards; the hospital always had a resident surgeon, and through the years the position was held by: Dr. Benigno Souza, Dr. Rafael Nogueiro, Dr. Manuel Costales Latatu, Dr. Ricardo Machin and Dr. Jose Lastra. The next building had the Canizares-Arteaga ward on the ground floor; it was the Obstetrical Department and the chairman was Dr. Alberto Sanchez Bustamante who was Professor of Obstetrics in the medical school. The upper floor was the Mestre-Zayas ward for surgical patients; the chairman was Dr. Ricardo Nunez Portuondo, a brilliant surgeon who later played important political roles in the country. In 1948 he was a candidate for the presidency of the Republic in the general elections. Dr. Nunez Portuondo developed a school of young and courageous surgeons who spread around the country the skillful techniques of their teacher. In this row the last building contained the Landeta-Grande-Rossi wards on the ground floor; the chairman was Dr. Luis Ortega, Professor of Internal Medicine at the medical school. On the upper floor was the Yarini ward for surgical patients; the chairman was Dr. Jose A. Presno, Professor of Topographic Anatomy and Surgical Techniques at the faculty. The other half of this floor was for treatment of drug addicts, and Dr. Miguel A. Branly was in charge.

The fourth row had its east end facing the old wooden hospital; the first building was the kitchen and the second, the warehouse. The third building

behind the obstetric ward had the Galvez ward on the ground floor for traumatology, and the upper floor was the Albarran-Bango ward for urology. Albarran was a famous Cuban urologist, Professor of Urology at the University of Paris, who introduced important changes in the instrumentation for endoscopic examination of the bladder. Chairman of this ward was Dr. Luis F. Rodriguez Molina who later would be Professor of Urology in the medical school.

The last building was named Gordon for an old Professor of Anatomy; it had a hold-room for deceased patients and the autopsy department.

There was a last building in the center of a line that in the future could become a fifth row. It was devoted to internal medicine and was named Torralbas, honoring the memory of a physician who fought in the Cuban army during the Independence War and later did valuable services to the health department during the first years of the Republic. The chairman was Dr. Enrique Saladrigas, Professor of Internal Medicine in the medical school.

In the first row a new building was added on the east end, a maternity hospital, and its director was Dr. Carlos Huguet.

This was the morphology of the hospital in 1923. As one can see, there were two divisions of the government ruling the hospital: the Health Department and the University of Havana, neither had authority over the other. The year 1923 was a significant year for the university, the students revolted against the teaching system and tried to improve it. One of the targets was the hospital organization, and in October of that year the Dean's office was moved into the hospital as a first step to get absolute control of it. From then on, the influence of the university was continually growing.

In 1925 a one story building was completed for the Department of Otolaryngology. The building was named Emilio Martinez, honoring the first E.N.T. professor at the faculty. Its wards were named Desvernine, each one with twelve beds. Dr. Carlos Desvernine was one of the first Cuban otolaryngologists trained in Europe. It was said that he first described velo-palatine-vocal cord paralysis, today known as the avellis syndrome. The chairman was Dr. Claudio Basterrechea, professor at the medical faculty, and his associate was Dr. Emilio M. Martinez, Jr., who had his postgraduate education in Europe and in the U.S.A. He loved microscopic pathology and taught this discipline to many young doctors who later became distinguished pathologists. He was interested in cancer as a surgeon, patholo-

gist and radiotherapist, and wrote interesting papers about this disease. In the building there was a Broncho-Esophagological Department headed by Dr. Pedro Hernandez Gonzalo, a pupil of Chevalier Jackson. There were three operating rooms, and equipment for inhalation therapy, and there were two outpatient departments; one to be used in the teaching of medical students where the patients were examined on their first visit, and another attended by young otolaryngologists in training.

A big building, which for many years had only its walls and roof, was finished in 1925. It was located behind and at some distance from the Emilio Martinez. It was to be the Department of Dermatology, whose chairman, Dr. Vicente Pardo Castello, was Associate Professor of Dermatology, and later became President of the American Society of Dermatology. Its upper floor was the new ward for the veterans of the Independence War.

Between this building and the Otolaryngology Department was a smaller one story ward, the Margarita Nunez, that was used by the nurses. The old wooden wards, Miss O'Donnell and the Veterans, were demolished opening space for new constructions.

A new building was finished for the Ophthalmology Department and named J. Santos Fernandez, in honor of one of the pioneers of this specialty in Cuba. The chairman was Dr. Jesus M. Penichet, Associate Professor at the faculty, and later Professor and Head of the Department. Here, like in the Otolaryngology Department, young doctors received their postgraduate education in these specialties.

In 1928, profiting from the room left by the wooden wards already demolished, the Cancer Institute was completed while Dr. Carlos M. de Cespedes was the Secretary of Public Works. The institute fulfilled the ambitious desires sustained through six years of enthusiastic and well-aimed work of the Cuban League Against Cancer; the League had had its origin in the 1922 Cuban Medical Congress and was joined by physicians interested in cancer, socialites, bank directors, sugar industry executives, and others who along the years gave the League their support, and very soon it was joined by all the Cuban people. The first director of the Institute was Emilio Martinez, former Dean of the faculty. It had four wards for charity patients with a capacity of ninety beds, and a smaller ward for private patients with twelve beds. There were radiotherapy and radium therapy departments, an excellent surgical service, and an outpatient clinic, a pathology laboratory, general laboratory and an

autopsy department. The service that the Cancer Institute gave to the community was great. The League provided the economic resources to print two journals: the Bulletin of the League Against Cancer, a scientific publication sent free to all physicians in the country and medical libraries abroad to keep country doctors duly informed about the early symptoms of cancer and its treatment, and a Social Bulletin for the League benefactors informing them about the fund administration. The Cancer Institute was the only Cuban hospital recognized by the American Hospital Association. It is worthwhile to point out that with the exception of the heads of specific departments such as radio therapy and radium therapy, the resident surgeon and the laboratory chief, the whole staff from the director to the heads of the different specialties were honorary positions.

Under the presidency of General Gerardo Machado, and Dr. Francisco M. Fernandez being his public health secretary, improvements were made in the building lodging the Cabrera-Saavedra wards; the building now was named the Francisco M. Fernandez Clinic and the chairman was Dr. Jose Bisbe, Professor of General Pathology. Dr. Bisbe had been a distinguished medical student, the first of his class. He dedicated a great portion of his leisure time to the organization of the Cuban Medical Federation, later the Cuban Medical College, where he was secretary and later its president. He was an enthusiastic and convincing speaker and his lectures a model of clarity. His associate was Dr. Fernando Milanes who had a solid reputation as a gastroenterologist. Combining their efforts, the clinic, actually an internal medicine department, offered an effective care to the patients admitted to the facility.

In 1933 Dr. Ramon Grau San Martin, Professor of Physiology was the president of the Republic, and Dr. Manuel Costales Latatu his education secretary. They decided that the University of Havana should be autonomous and a generous budget was assigned to meet its expenses and improvements.

In the meantime the drug addicts were moved to another facility; thus there was one more available ward. It was placed under the care of the Department of Clinical Therapeutics whose chairman was Dr. Antonio Valdes-Dapena.

In 1939 Colonel Federico Laredo-Bru being the president of the Republic, the congress passed what was called the Docent Law. This law guaranteed total independence of the university from the government, and the General Calixto Garcia Hospital came under the control of the faculty of medicine; that is, a university hospital.

The hospital began to be ruled by a Committee of Trustees nominated by the faculty. Members of the committee served for four years and the position was without pay. The committee named the director of the hospital, whose role was to accomplish the decisions of the trustees, who in turn were responsible to the faculty. A sophisticated administrative system was established and with all these changes, the hospital began a new life.

The quarters of the Emergency Department were given to the Department of Parasitology and its chairman, Dr. Pedro Kouri, who was the professor of this discipline in the faculty, started enthusiastically to do research on patients afflicted with parasitic diseases who had been admitted to the internal medicine wards.

When the Romay Tuberculosis Hospital was demolished to make room for the Children's City Hospital, the teaching of that disease in the faculty suffered a set back. The Professor of Tuberculosis was Dr. Alfredo Antonetti, a man of faith and a hard working physician. In 1929-1930, years of the economic depression when one could buy a cigar in the streets for one penny, he began the task of building a new tuberculosis facility, this time within the hospital. As the economic situation was touching bottom, Dr. Antonetti had to face many difficulties. Later he got in trouble with the government of Dr. Ramon Grau San Martin, who tried to centralize all patients with tuberculosis in a big hospital, The Hope, which specialized in this disease and was located in the outskirts of Havana. Dr. Antonetti did not accept the government decision and continued his struggle for a building in the General Calixto Garcia Hospital. There were changes in the political situation in the country, and changes in the political ruling of the hospital, and finally Dr. Antonetti fulfilled his dream when a building was kept for his patients in the University Hospital as the old General Calixto Garcia was now called.

The position of professor in one of the internal medicine departments had been vacant after the death of Dr. Enrique Saladrigas. Dr. Pedro A. Castillo, who had been associate professor in the department of Dr. Luis Ortega, gained that position after brilliant competitive examinations. Dr. Castillo had been the first among the students in his class and his postgraduate education had been in Germany and France. He published several scientific papers and was a fine speaker; he was widely known for his knowledge and may have been the most outstanding internist in his time. He was the personal physician of the last five presidents of the Republic.

In 1944 Dr. Moises Chediak, Professor of Microbiology and Clinical Chemistry, who was recognized as one of the most distinguished hematologists in the Caribbean area, tried to open the first Hematology Department in the hospital. Supported by Dr. Ricardo Nunez Portuondo he obtained the basement of the Mestre-Zayas ward. He personally donated the equipment and beds and started to work in rather humble conditions. Four years later the Trustees Committee, headed in those days by Dr. Manuel Galigarcia, improved the central laboratory, and a better area was dedicated to the hematology wards. Finally, in 1950 Dr. Carlos Prio Socarras being the president of the Republic, a grant was given to Dr. Chediak and a new building was built for a complete Hematology Department with beds for children, men and women.

In 1946 Dr. Tom D. Spies, professor at the Cincinnati Medical School, obtained a grant to make nutritional experiments with the recently discovered folic acid. He was well known for his research on the treatment of pellagra with nicotinic acid, and the faculty received him as a visiting professor. One of the wooden buildings still usable was totally repaired and equipped for him. With the cooperation of Drs. Guillermo Garcia Lopez and Fernando Milanes from the general pathology department, and with the assistance of Dr. Aristides Menendez, a young and dynamic physician, and later Dr. Tomas Aramburo, Dr. Spies showed for the first time the curative action of folic acid in macrocytic and megaloblastic anemia. Later he went to the University of Alabama in Birmingham where he wrote several papers describing the results obtained.

Without interference from the faculty, the Cancer Institute had continued with its original organization, and both scientifically and socially, the institute fulfilled its aims. But in time the League Against Cancer realized that its bed capacity was not enough for the increasing number of patients needing admission, and they decided upon the construction of a new hospital. President Fulgencio Batista offered an open space which was the property of the government; the Falla family who had supported the League during all its life gave a large donation, enough to build a complete outpatient clinic, and the government finished the hospital. It was named the Curie Hospital and officially inaugurated in the first months of Dr. Carlos Prio Socarras government at the end of the year 1948.

With this inauguration, the Trustees Committee had a new and well-built facility at its disposition. One of the hospital's deficiencies was a lack of a

Department of Neurosurgery. The trustees took advantage of the opportunity and the upper floor of the Cancer Institute was organized and equipped for a neurosurgical facility. Its chairman had to be Dr. Carols Ramirez Corria who was the first neurosurgeon in Cuba. Prior to this he had to spread his patients in the different surgical wards which was a source of difficulties. Now in his new department he was in better condition to treat his patients and to teach the interns and assistants.

In the meantime, some changes had to be made. The ground floor of the Francisco M. Fernandez Clinic was allotted to the Department of Medical Pathology which had no hospital facilities. Basically, it was an internal medicine department whose chairman was Dr. Pedro Iglesias Betancourt, a brilliant and idealistic student of medicine who completed his medical studies at the University of Paris. There, after a competitive examination, he won the position of intern of the hospital which was eagerly sought among the young graduates. He shared his department with his associate, Dr. Juan M. Portuondo de Castro, an excellent teacher. In the basement there was a small auditorium where, headed by Dr. Iglesias, a small group of internists, otolaryngologists, neurologists and ophthalmologists, a true otoneuro-ophthalmology group, met once a week to discuss patients involving these specialties.

The Torralbas ward had maintained its original organization, but now the chairman was Dr. Jose J. Centurion, formerly the associate of the late Dr. Enrique Saladrigas. Dr. Centurion had a great experience as internist and as teacher. Cardiology was his sub-specialty and his sense of responsibility made him a respected personality in Cuban medical and scientific societies.

In the Landeta-Grande Rossi ward a new chairman, Dr. Carlos Cardenas, had been appointed after the death of Dr. Luis Ortega. Dr. Cardenas, one of the first students of his class, had been attached to this ward since he was an intern and was highly respected by his students and the members of his staff. He shared the department with his associate, Dr. Rogelio Lavin, who took care of the patients admitted to the upper floor, the Yarini ward. Dr. Lavin had been a first class student and taken his postgraduate education in Germany. Very soon the section occupied by the Department of Clinical Therapeutics was moved to a new building, and Dr. Lavin took care of the whole floor.

The Department of Clinical Therapeutics was the new name of the old Therapeutic Department. When it was moved to the new ward, Bacallao, it increased

the number of beds and improved its equipment. Bacallao was the name of a young doctor who died while fighting in the revolution against President Machado. The building never was completely finished; in 1958 still there was a wooden stairs on the outside to provide access to the main floor. This new building was another Department of Internal Medicine; its nominal chairman was Dr. Antonio Valdes-Dapena, but he had released all his responsibilities in the hospital to one of his associates, Dr. Rodolfo Sotolongo, who actually was charged with the care of patients and the teaching of this subject. Dr. Sotolongo had written poetry in his youthful days, he had an attractive personality and great experience in teaching, he took his job with great interest and his classes were well attended.

In the same way that the nurses had a ward for the care of the members of their association, the Cuban Medical College strove for a building to be used by its members. The college got it and it was placed to the west of the Department of Otolaryngology. The facility, with two stories, had an operating room, and its building, equipment and maintenance was under the care of the medical college. It was named Borges honoring the memory of Dr. Jose E. Borges who died in the revolution against President Machado.

The hospital grew until 1200 beds were available to be used by charity patients and sometimes,

considering that patients were coming from the whole country, that number was not enough. There were some small and scattered sections for private patients. The City of Havana had several private patient hospitals and they rarely chose the General Calixto Garcia if they needed to be admitted.

At the end of the year 1958 when this history ends, the 1200 beds were distributed in the seven departments for internal medicine: Landeta-Grande-Rossi, Torralbas, Weiss, Yarini, Bacallao, Cabrera Saavadra-Jacobsen, and Francisco M. Fernandez; one department for dermatology, hematology and parasitology. Three departments for surgery: San Martin, Mestre-Zayas and Enrique Lopez; one department for urology, traumatology, neurosurgery, otolaryngology, and ophthalmology; one central laboratory, one maternity hospital, and one autopsy and pathology department; finally, the two small hospitals for nurses and physicians.

This was the final pattern of the University Hospital; its life was a mirror of the life in the country. There had been many changes since the year 1913, but always scientifically progressing, improving as a public service facility and being an invaluable school for the education of the young physicians.

The author expresses his gratitude to Mrs. Antonio Lastra, Drs. Aristides Menendez, Rodolfo Sotolongo, Moises Chediak, and to many others who gave many details for this history.

Medical Care in Castro's Cuba Today*

In order to have a complete understanding of the practice of medicine in Cuba, one must first recognize that the Cuban society is a regimented society. This fact results in the absence of individual liberty and the reign of party politics over all areas of life in the country: political, social, economic, cultural, and scientific. Because of this, even those matters which appear to be of real benefit to the people are designed only for a political end which can thus convert them into a real detriment. This inevitably happens in all regimented

societies where liberty is non-existent and the rule is by the dictatorship of one person or a small group.

Education

There is mass education but its benefits are distorted by the manner in which it is imparted. Directed to accommodating the mind of the student to blind obedience to the dictates of the party, which actually means the will of the one in command, history is blatantly distorted, denigrating everything that doesn't fit the interests of international Communism. Students are expected to fulfill tasks which have nothing to do with their education such as agricultural work and political activities. Thus the

*The statements in this paper are those of a knowledgeable refugee who arrived in this country a few months ago. He would not allow his name to be used lest retributions be wreaked upon his family remaining in Cuba.

so-called "free education" has perhaps been very well paid for by the student.

Further, once preuniversity studies have been completed, the student does not have the freedom to choose the career that fulfills his likes or capabilities, but must follow the career indicated to him according to the interests of the moment and within the total regimentation of the life in that country. At first, "the universalization of the university" was proclaimed. That is, all citizens of the country were to have the right to go to the university and the "Worker and Farmer Department" was created in order to facilitate access to these studies by the workers and the farmers. That was to change and in 1976, there were 14,000 preuniversity graduates with no possibilities for pursuing a university career. They were only offered the possibility of employment in trade or business.

Selection of Students

Each preuniversity student is assigned a group of registrations for the different schools of the university. Those of the School of Medicine are few in number, sometimes two or three, which will be awarded to those students who have a good school file. The determining factor is their attitude and political militancy. This is the way in which a student's freedom to choose the university career of his preference has disappeared.

The Organization of Medical Education

Medical education is free and the textbooks are made available to the student without charges of any kind. From the first years, he or she must undertake hospital practice, for which there is a teaching faculty in the different hospitals adjoining the schools of medicine. Technically, this represents the possibility of receiving an adequate integrated education. However, the reality doesn't always bear up this possibility, for the teaching staff is not of the best quality and the teaching is inferior.

Another aspect of paramount importance is what might be termed a dehumanization in the treatment of patients. This attitude is taught beginning with the student days and is later maintained through new medical promotions. There is no easy explanation for this within the theoretical postulates of Communism, but it serves to demonstrate once more the abyss that exists between the theory and the practice of that doctrine. Here is a basis for the fear and repugnance on the part of the sick for hospitals, especially the teaching hospitals.

Postgraduate Education

Once the program of studies is completed, one is under the obligation to practice for two or three years in the rural zones of the country. The place of destination is not determined by academic record but by political record. Those students who have distinguished themselves by their political activism may spend their rural period in one of the provincial capitals under the best of conditions. On the other hand those who didn't engage in such activities will go deep into the country under extremely difficult conditions. Once the so-called "rural medicine" is completed, the doctor may be forced to remain in general practice, a field in which working conditions are deplorable. The salary is around \$200 a month. Foreign medical magazines and journals are accessible in a limited and irregular manner to specialists, but not usually to the general practitioner. The opportunities of buying books are scarce and, outside of the basic texts, are also available only to specialists.

Specialization

In order for the doctor to become a specialist, a residency is required, but again the residency positions do not always go to the most academically qualified. Each year a certain number of residencies are placed at the disposal of the graduates and, as in all activities in the country, the deciding factor is a political one. Once finished with his residency the doctor must accept whatever part of the country he is assigned to. Once again, the political factors decide the location of the young specialist. The salary for a young specialist is around \$300 a month and they are prohibited from engaging in private practice, thus their salary is their only income.

After almost 11 years of study and sacrifice, the Cuban doctor finds him or herself with the title, "Specialist," a monthly income of \$300 and no facilities for obtaining a home, automobile, books or any additional benefits. Added to this are the difficulties, because of the limited means available (instruments, research opportunities, auxiliary personnel, etc.), of working under poor conditions as well as an excess of working hours aggravated by being required to stand night watches as a militiaman and work on holidays. These matters encourage the doctors to pursue specialties which are relatively "easy" such as: Epidemiology, Labor Medicine, etc. This portends dire future consequences for the medical care of the population.

Medical Practice

There are two forms of medical practice, private and state. There still exist private practitioners but in a very limited quantity and progressively fewer in number. Their existence is considered practically criminal by the authorities and is only indirectly sanctioned. Thus, for example, they are unable to buy an automobile. They must resign their posts if they are university professors or if they want to continue to belong to the so-called revolutionary organizations. This has made many doctors withdraw from private practice.

The private practitioner faces great obstacles because of the lack of adequate clinical laboratories, the scarcity of radiologists, the scarcity of medicine for the care of the sick in their homes and the impossibility of admitting private patients to the existing hospitals. All of the above, together with the laws prohibiting new doctors from entering private practice contribute to make this form of medical practice disappear in a more or less brief span of time.

State medical aid is given through two institutions, polyclinics and hospitals.

The primary unit is the polyclinic. These provide medical attention to the people who are not hospitalized and according to the different topographical sectors into which the townships are divided. Polyclinics are of two kinds: Integral, with limited services because of limited facilities, and Regional, covering almost every specialization and providing services for several Integral Polyclinics.

The number of physicians in the polyclinics has no relation to the population of the clinic's corresponding sector. The excess workload of the doctors and the great difficulties encountered by patients in obtaining medical care stems from this fact. It is necessary to stand in line from the pre-dawn hours in order to get an appointment which may then turn out to be for several days or weeks later. Recently, the previous denomination of the polyclinics was changed to "Communitarians" and their manner of providing services was modified. At the present time, the region corresponding to each polyclinic has been subdivided into areas or sections, each one attended by one doctor who has under his care all of the patients of that area or section.

No adequate proportion has been established between the number of patients and the available doctors, so that the problems of excess workload for these doctors and the difficulties for the patients have continued. A new circumstance has arisen to worsen the situation, the inhabitants of each area

or section can only be seen by the doctor of their corresponding area or section.

Hospitals

Hospitals are divided into urban and rural according to their location and further into teaching and non-teaching and specialized or general. There are psychiatric, obstetric and gynecological, orthopedic, pediatric and neurological hospitals and leprosariums. There exists also what are called "Institutes" which offer medical attention in a limited manner for they are supposedly research centers. Among these are institutes for cardiology, nephrology, gastroenterology and endocrinology. These institutes are actually propaganda oriented showpieces for foreign visitors and in general are endowed with quality equipment, mostly from the western countries. The benefit derived from these centers by the common people is very limited and the quality of their investigations is doubtful.

There has been an improvement in hospital care because some hospitals have been created in rural zones where before there were not enough facilities and old hospitals have been repaired. This has permitted the regime to make exaggerated propaganda claims about the actual benefits of hospital care in Cuba. It is no less true that the Communist regime in Cuba covers up the level of development reached by a form of socialized medicine called mutualism. Under this system which preceded Castro, for a monthly fee that ranged from \$1.50 to \$3.50, every Cuban could have his medical care assured including laboratory tests and medicines in a very acceptable manner.

Hospitals, like the polyclinics, serve a specific geographical region or area. Each hospital serves several polyclinics within its zone and to which it makes its services available. It can be said that hospital care is more or less satisfactory currently. It should be pointed out that there is a general feeling of repulsion for the teaching hospitals. Patients complain about being seen each time by a different doctor, on occasion solely by a student, and of being treated in a dehumanized manner, "like inanimate objects." Quite frequently they are released before they are cured either because of lack of beds or the poor judgment of the responsible physician. This is a reality that can be observed daily, particularly in surgical care. It could be argued that it is acceptable for the patient to complete his recuperation in his own home in order to make available necessary hospital beds for more severe cases. This might be true anywhere else but in Cuba, where a patient

being cared for at home has the least amount of facilities for his care. It is totally impossible, given the food provisions of the population, to carry out an adequate diet for recovery from an illness or operation. Medicines in the drug stores and for the use of the public are totally insufficient and extraordinarily expensive. Furthermore, the purchasing power of the people is low indeed. A Cuban's average salary must not be over \$150 a month. In addition, the care of a patient in the home is greatly limited by the scarcity of bedding, soap, cleaning materials, disinfectants, etc.

The doctor's work in the hospital is hard and difficult. The number of paramedical personnel is greatly insufficient and, what is worse, they are poorly qualified in general. In view of the fact that people working in the health care services receive no benefits whatsoever from the government in contrast to people working in other fields, these personnel must be recruited from among those who have been unable to find positions in other departments of the public service field. In general, therefore, they are people of low cultural level and little sense of responsibility.

Scientific Medical Development

The physician has few opportunities for obtaining books and medical journals of significant quality, thus, generally speaking, their information is almost 20 years behind modern medicine. The new and sophisticated methods of investigation presently in existence are only displayed for propaganda purposes in the so-called Institutes. The greater part of the hospitals lack advanced investigative means and the doctors do not have available the elements necessary to make a correct diagnosis or confirm what they suspect.

There is one particular circumstance that is worthy of note. In Havana there is a center that manufactures the reagents used by the different laboratories in both hospitals and polyclinics. With relative frequency and due to the low quality control, reagents are made and distributed to the laboratories that cause epidemics (uremia, diabetes, syphilis) which disappear when the faulty reagent is discovered.

The organization for the administration of the hospitals is theoretically correct but due to the overriding political considerations, this organization accomplishes its purpose poorly. Likewise, due to political motives, the administrative personnel are constantly being renewed and moved from place to place. This is a basic principle within the system,

for in this manner people cannot form a nucleus which might at any moment constitute a center of power. These constant changes coupled with the lack of capability, produce serious organizational and operative breakdowns at all levels.

Preventive Medicine

In the field of maternity care the government has tried to maintain the level of care that existed before Castro rose to power. It can be said that in Cuba all births take place institutionally as was previously true and that prenatal medical attention is satisfactory. In preventive medicine the government has made great propaganda claims that poliomyelitis has been eradicated only since Castro came to power. This is not correct. Vaccination against polio began well before Castro and was highly successful. Until quite recently malaria had been eradicated but Cuba's involvement in Africa and Africa's involvement in Cuba has given rise to cases of malaria with the possibility of a new resurgence of the disease. Similarly, as a consequence of the exchange of personnel from regions with a high incidence of infectious diseases of all types, Cuba faces serious potential dangers.

Public Health

Curiously, the control of infectious diseases contrasts with the poor sanitary conditions that currently prevail. The shortage of, and in some areas total and permanent lack of, water leaves much to be desired in the area of cleanliness, both in the home and in public places. Garbage pickup is very deficient and it is no rarity to see all types of waste accumulated in public places. Nor is it a rare sight to see breaks in the drainage system with decomposing material spreading through the street. For a long time, in the middle of Havana at Prado and Virtudes Streets, fecal matter has been seen on the public thoroughfare, not just once, but for prolonged periods of time. It is both interesting and curious to read the reports of persons who have visited Cuba, as well as the reports from international organizations which praise the sanitary conditions of the country. The naivete of these persons who are so easily satisfied with what they are shown is amazing. The questions might be asked: "Can good sanitary conditions exist in a country where there is such a shortage of water?" and "can a tropical country guarantee good conditions for its food when electricity suffers interruptions for interminable hours at a time?" The fact that habitual means of disease prevention have lowered the incidence of infection

does not, to my mind, justify talk of good sanitary conditions. Many times the thought comes to mind of what Cuba would do without her permanent sun, when you see a queue of people waiting to drink coffee (when it was available) in cups that are cleaned by submerging them in a basin of water that is seldom changed, or when you see extensive geographical areas without running water for basic human use.

It can be said that the Cuban doctor today, in general, lives in stagnation, disillusionment, and

with no stimulus or desire to progress. He or she only tries to live as best they can. We believe that this is also the state of mind of the majority of the population. Furthermore, while living conditions become more difficult for the mass of the population one observes how they get better and better for the party bureaucracy and the higher levels of the country's administrators. It is evident that in Cuba today in order to survive one must abandon all independent thought and initiative and submit to the inexorable demands of the Communist government.



This photograph was taken during the International Cuban Medical Association Congress of 1977. It enhances the moment of reunion at the invitation of Dr. Enrique Huertas, President of the Cuban Medical Association with some of the physicians who participated in the work of Cuban Medicine. Dr. William M. Straight, Historical Editor of the Journal, officially received the papers published in this issue. (From left to right): Dr. Jorge Beato; Dr. Frank Canosa; Dr. Guarino Radillo; Dr. John H. Budd, President of the American Medical Association; Dr. William M. Straight, Historical Editor of the FMA Journal; Dr. Louis C. Murray, President of the Florida Medical Association; Dr. Eliseo Perez Stable, Scientific Director of the Congress; Dr. Augusto Fernandez Conde, Former President of the Cuban Medical Association; and Dr. Enrique Huertas, President of the Cuban Medical Association and Guest Editor for this issue of the Journal.

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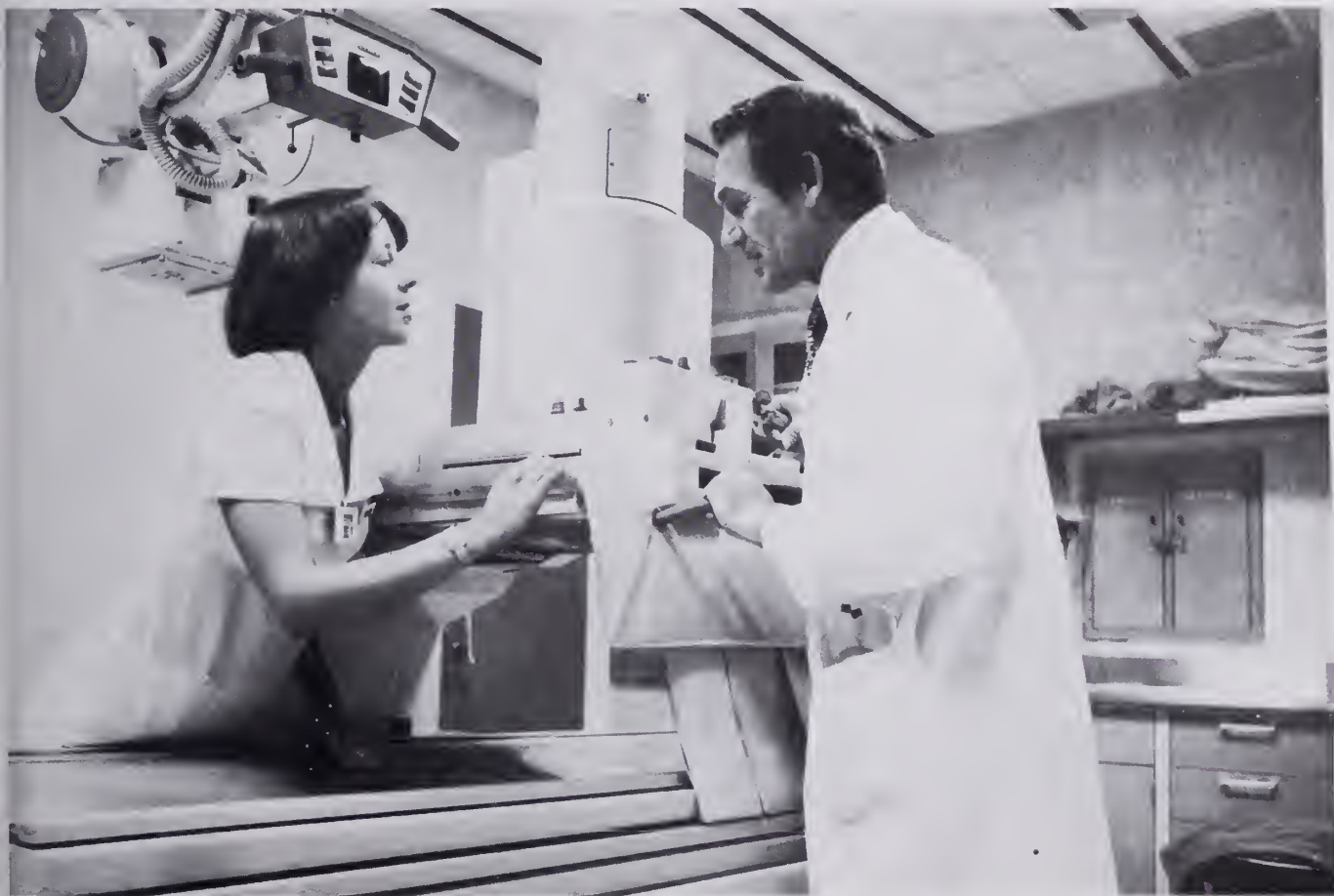
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Dr. Edward R. Annis Appointed To Revision Commission

State Senate President Lew Brantley (Dem.-Duval) has appointed Edward R. Annis, M.D., of Miami, to Florida's Constitution Revision Commission.

Dr. Annis is a Past President of the American Medical Association.

Attorney Talbot D'Alemberte of Miami is Chairman of the Commission, which held its first meetings in Tallahassee, July 6-7.

Florida Wins AMPAC Leadership Recognition Award

Florida has won a "Leadership Recognition Award" from the American Medical Political Action Committee (AMPAC).

During ceremonies conducted in San Francisco on June 19, AMPAC presented the awards to states whose entire leadership delegations became sustaining members of AMPAC in 1977. Leadership includes the state medical association president and president-elect, AMA delegates and alternates and state political action committee chairman.

Florida's award was presented by AMPAC Secretary Michael P. Levis, M.D., of Pittsburgh, to John W. Glotfelty, M.D., of Lakeland, Chairman of the Florida Medical Political Action Committee.

Dr. Dobbins is Reappointed to AMA Judicial Council

Burns A. Dobbins, M.D., well known Ft. Lauderdale pediatrician, has been appointed to a second five-year term on the Judicial Council of the American Medical Association.

In addition, he was elected Chairman of the five-member Council.

Dr. Dobbins, who has served as an AMA Delegate from Florida for several years, was reappointed by John Budd, M.D., of Ohio, AMA's new President.

His original appointment five years ago was made by C. A. Hoffman, M.D., of Huntington, W.VA., then President of AMA.

A Review of Florida's Major Comprehensive Medical Liability Laws — 1975 thru 1977

W. Harold Parham, D.H.A. and John E. Thrasher, J.D.*

During the past three years the Florida Legislature in recognition of the medical malpractice insurance crisis has adopted several remedial pieces of legislation in this field. The major professional liability legislation which has been enacted during the past three years includes the following provisions which were actively sponsored and promoted by the Florida Medical Association, its component county medical societies, recognized specialty groups and others:

- THE ESTABLISHMENT OF MEDICAL LIABILITY MEDIATION PANELS WHICH PROVIDE FOR THE FILING, HEARING AND DISPOSITION OF MEDICAL MALPRACTICE CASES.
- A MAJOR REVISION IN THE STATUTE OF LIMITATION FOR MEDICAL MALPRACTICE CLAIMS.
- ELIMINATION OF AD DAMNUM CLAUSE.
- ESTABLISHMENT OF CRITERIA FOR DEALING WITH INFORMED CONSENT.
- STRUCTURED PAYMENT OF DAMAGES WHEN THE JURY AWARD FOR ALL FUTURE DAMAGES IS \$200,000 OR MORE.
- ITEMIZED VERDICTS.
- DEFINITION OF SIMILAR HEALTH CARE PROVIDER.
- DEFINITION OF MEDICAL PROFESSIONAL NEGLIGENCE.
- APPLICATION OF COLLATERAL SOURCES IN JURY TRIALS AS A DIRECT OFFSET.

—ELIMINATION OF THE USE OF RES IPSA LOQUITUR DOCTRINE.

—ESTABLISHMENT OF A REMITTITUR-ADDITUR PROVISION ALLOWING ADJUSTMENTS BY THE COURT OF CERTAIN JURY VERDICTS.

The Legislature also adopted other major legislation relative to medical liability that include the following:

- A Hospital Risk Management Program requiring that all hospitals as a part of their administrative functions establish an Internal Risk Management Program.
- Creation of the Temporary Joint Underwriting Association to provide Medical Malpractice Insurance for Physicians, Hospitals, Osteopaths, Podiatrists, Dentists, Nurses, Nursing Homes, and Professional Associations.
- Creation of a Patients Compensation Fund to pay that portion of all claims in excess of \$100,000.

A summary of the major provisions of these laws dealing with Medical Liability is as follows:

MEDICAL LIABILITY MEDIATION PANELS —

This law requires **any person claiming damages on the account of alleged malpractice by a physician Osteopath, Podiatrist, Hospital, or Health Maintenance Organization to submit their claim to a medical liability mediation panel before that claim can be filed in any court of this State.** The panel consists of a Judge, a Lawyer, and a Doctor. The law provides further that the claim will be submitted to the panel under procedural rules established by the Supreme Court of Florida. The law further provides that within 30 days after the completion of the hearing the Hearing Panel shall file a written

*Dr. Parham serves as FMA Executive Vice President and Mr. Thrasher serves as FMA Legal Counsel.

decision as to whether the defendant was actionably negligent in his care or treatment of the patient. The Statute allows the panel, if the parties agree, to continue mediation if necessary to assist the parties in reaching a settlement by making a recommendation as to the reasonable range of damages. The Statute further provides that the claimant may institute litigation if either party rejects the decision of the panel. The Statute allows the defendant to waive mediation by not filing a responsive pleading to the original claim. If the defendant fails to file a responsive pleading within the 20 day time period allowed, the claimant may then file his claim directly in the Circuit Court. The Statute allows the panels finding on the issue of liability to be admitted into evidence at a subsequent jury trial and the Supreme Court of Florida has construed the Statute to allow the fact of the defendant's failure to mediate to be admitted into evidence in a subsequent jury trial. The law provides payment of \$100.00 a day for expenses for the physician and attorney member of the panel to be assessed by the court equally between the defendant and claimant. The Florida Supreme Court has in the case of *Carter vs Sparkman* 335 So2nd 802 (Florida 1976) upheld the constitutionality of the medical mediation statute. Moreover, the Supreme Court of the United States has declined to review this decision. (Certiorari denied 45 USLW 3459)

MODIFICATION OF STATUTE OF LIMITATIONS — This law sets the Statute of Limitations for Medical Malpractice claims at **2 years from the time the incident occurred, or 2 years from the time it is discovered**, however, **in no event shall the action be commenced later than 4 years** from the date of the incident or occurrence out of which the cause of action accrued.

AD DAMNUM CLAUSE — This law prohibits the amount of damages sought by the claimant from being stated in the actual complaint.

INFORMED CONSENT — This law basically provides that **no recovery shall be allowed** in any court in this state **against a Physician, Osteopath, Chiropractor, Dentist, or Podiatrist** in an action brought for treating, examining, or operating on a patient without his informed consent **where** the action of health care provider in **obtaining the consent** of the patient or another person authorized to give the consent **was in accordance with the accepted standard of medical practice** among members of the medical profession with similar

training and experience **in the same or similar medical community**; and a reasonable person would have understood the risks and the patient would have undergone the treatment had he known the risks involved. The Statute provides that a consent which is evidenced in writing and meets the requirements of this law and if validly signed by the patient or is authorized representative shall be considered conclusively to be a valid consent.

STRUCTURED PAYMENT OF DAMAGES — This law provides that **when a jury award for all future damages in a medical malpractice case is \$200,000 or more**, then **either party may request** the court to require that those **future damages be paid out over a period of time** rather than in a lump sum but the past damages will be paid immediately in a lump sum. This law additionally provides that if the claimant lives longer than the period of time in which such structured payments are to be made then such payments shall continue for the remainder of the claimant's life at the same rate as the payments being made at the time they would have otherwise terminated.

ITEMIZED VERDICT — This particular law provides that **if a jury finds the health care provider legally liable it must itemize the damage award** into the following categories: Medical Expenses, Lost Wages, and other economic losses, and general damages (the intangible losses most often characterized by pain and suffering). Additionally, this law provides that the jury will further breakdown the award into the amounts in each of the categories which have already been incurred (past damages) and those awarded for expected future losses, expenses, and general damages.

DEFINITION OF SIMILAR HEALTH CARE PROVIDER — This law defines a similar health care provider for a physician who is or holds himself out to be, a specialist as someone who is certified in the same specialty by the appropriate national board. A similar health care provider for general practitioners is someone licensed in Florida in the same discipline and who practices in the same or similar medical community.

DEFINITION OF MEDICAL PROFESSIONAL NEGLIGENCE — This particular law provides that in any action for recovery of damages based on the death or personal injury of any person in which it is alleged that such death or injury resulted from the negligence of a health care provider, including a physician, **the claimant then shall have the burden**

of proving by the greater weight of evidence that the alleged actions of the physicians represented a breach of the accepted standard of care for that physician.

THE COLLATERAL SOURCE PROVISION —

This law provides that the sources of insurance and other benefits known as collateral sources of indemnity will be subtracted from any medical malpractice judgement that the claimant gets in a law suit. However, this Statute does exclude future collateral sources from being subtracted from the verdict. As an example, if the claimant received an award of \$5,000 from the jury and the claimant has had \$2,000 in medical bills paid prior to the jury award by accident or health insurance then the court will subtract that amount from the jury verdict and enter a judgement after the subtraction for net recovery of \$3,000. The Statute also provides that the claimant will receive credit for amounts he has paid for the benefits received (premiums for insurance) and the reduction in the verdict will be offset by these amounts.

RES IPSA LOQUITUR DOCTRINE — This law provides for the prohibition against the use of Res Ipsa Loquitur in medical negligence cases except where a foreign body, such as a sponge, clamp, forceps or surgical needle is left in the patient.

REMITTIUR AND ADDITUR PROVISION —

This provision provides that upon the request of a party to a suit the trial judge must examine the amount of the jury award in light of all the circumstances of the case and determine whether it is clearly excessive or inadequate. If a judge finds clear excessiveness or inadequacy based on his examination of the award, he may order that it be increased or decreased or order a new trial on the issue of damages if the adversely affected party does not agree with the remittitur or additur.

THE HOSPITAL INTERNAL RISK MANAGEMENT PROGRAM —

This particular law was first adopted during the 1975 Legislature and provided at that time that all licensed hospitals with more than 300 beds must establish an Internal Risk Management Program to evaluate the categories and types of medical incidents causing injury in the hospital. Under this 1975 provision they were further required to develop measures to minimize the risk of injury and analyze patient grievances relating to the care and quality of medical services. (In 1976 this Statute was expanded upon by the Legislature and in addition to the other functions of the 1975 act the law required that hospitals establish

a mandatory program providing for a method of advance payment for compensable injuries sustained by a patient in the hospital to be determined by a medical incident committee. The awards of the medical incident committee were binding on the physician and his insurer subject to certain appellate reviews.) This particular law was declared unconstitutional by a Circuit Court in Leon County, Florida in February of 1977.

The legislature again during the 1977 session attempted to refine this particular law in order to make it constitutional. The law in its present state, as adopted by the 1977 Legislature, now establishes the requirement that all hospitals shall as a part of their administrative functions establish an internal risk management program. This program shall provide for the investigation and analysis of adverse incidents resulting in injury to patients, the development of appropriate measures to minimize the risk of injuries and adverse incidents to patients and the analysis of patient grievances and the development and implementation of an incident reporting system. (The requirement that the hospital develop and implement a program to provide compensation to patients who had sustained injury in the hospital pursuant to the decision of the medical incident committee has been repealed and is no longer a part of the existing law relating to hospital risk management.) The law goes on to empower the Department of Health and Rehabilitative Services in consultation with the Department of Insurance to promulgate rules governing the establishment of the internal risk management programs for hospitals. These rules shall specifically require each hospital internal risk management program to include the use of incident reports as a means and a management technique for evaluating problems that are occurring in the hospital. Pursuant to the 1977 law, these incident reports shall be considered a part of the work papers of the attorney defending the establishment in any subsequent court case and shall not be admissible as evidence in court.

THE JOINT UNDERWRITING ASSOCIATION

— This law enacted in 1975 provides for medical malpractice insurance for physicians, hospitals, osteopaths, podiatrists, dentists, nurses, nursing homes, and professional associations. The law established the Joint Underwriting Association for a maximum of 3 years, and unless otherwise extended the JUA will terminate in 1978. The law provides that policyholders will pay a premium contingency assessment in the event that an underwriting deficit

exists at the end of any year. It sets the maximum assessment at one-third of the annual premium payment. The law further provides that if a deficit remains after the maximum premium assessments such deficits shall be recovered from the insurers participating in the plan and the proportion that their net premiums bear to the total net premium in the State.

PATIENTS COMPENSATION FUND — The Patients Compensation Fund was also established in 1975 to provide a fund to pay that portion of any claim in excess of \$100,000 for its members. Physicians participating in the Fund cannot be assessed more than one additional annual premium in any year.

SUMMARY — The Legislature has acted in a responsible manner in attempting to stabilize a complicating and highly controversial crisis. The

Florida Medical Association is proud to have been the primary moving organization behind these laws. The many hours of work by dedicated physicians throughout the State in support of the Association's legislative efforts has demonstrated the individual physicians' fearless dedication to providing the citizens of Florida with uninterrupted quality medical care. It is certainly our hope that the laws that have been enacted thus far will provide a system that protects the public while still maintaining the physicians' opportunity to provide each citizen with the necessary and needed medical services they deserve.

Thanks are extended not only to the officers and members of the Association but also to the Legislative Leadership, individual members of the Legislature, Legislative Consultants, FMA Staff and others who contributed to the enactment of these laws.

Dear Fellow Students:

As you think about your years after graduation, do you ever consider an involvement in organized medicine or even how and why such organizations exist? To help with some of these questions, let me recount some of the occurrences at the 103rd Annual Meeting of the Florida Medical Association, May 4-8, in Miami.

The House of Delegates, a representative group elected from each County Society, met on three occasions to hear reports and recommendations from the standing councils within the organization. Resolutions submitted by the component county societies were also heard and moved on. Important motions approved during this meeting included calls for changes in the Florida Drug Substitution Law, reenactment of the 1976 Malpractice Tort Reforms which have been thrown out in court, provisions for the "sick physician" and endorsement of the AMA bill for comprehensive health care insurance financed by the person, his employer and the federal government and managed through the private sector.

Election of officers for the coming year was also held and Dr. Louis C. Murray of Orlando was elected President. Dr. J. Lee Dockery of the Department of Obstetrics and Gynecology at the University of Florida was unanimously elected Vice President.

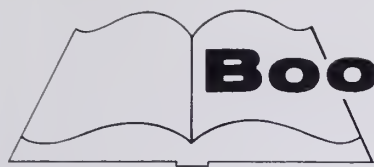
For the members of the Association, there were three days of educational meetings, presented by the various subspecialty groups within the state. Members of the private sector, faculty for the three state medical schools, and prominent national figures spoke in a "lecture-like" format. Attendance was credited toward one's Continuing Medical Education requirements.

Two observations that struck me after meeting with this group were that these physicians did not conform to the right-wing self-centered stereotype that many of us had of the AMA and organized medicine as students in the early 70's. I also realized the need, in this day of increasing regulations, for medicine to be organized, with definite, well thought out plans and goals in order to have a say in the practice of medicine in the future years.

If anyone has any questions, please feel free to contact me, Box J-816, J. H. Miller Health Center, Gainesville, Florida 32610. Student membership dues for the Alachua County Society are \$5.00 a year, Dade and Hillsborough Societies are \$10.00. The yearly dues to the FMA are \$10.00.

Sincerely,

Jim Campbell
Student Delegate,
FMA House of Delegates



Book Reviews

Book Review Editor

F. Norman Vickers, M.D.

Pathology of Disruptive Pulmonary Emphysema by A. E. Anderson, M.D. and Alvan G. Foraker, M.D. 239 Pages. Price \$18.50. Charles C. Thomas, Springfield, Illinois, 1976.

This volume is a true labor of love. It represents a major product of 20 years of devoted research carried out in the authors' personally created North Florida community hospital research laboratory. These disciplined investigators purposefully segregated time from their busy clinical and hospital practices to follow a line of classical research and teaching for the love of scholarship.

The authors' efforts are recognized in the foreword given by the eminent English authority on pulmonary and tropical diseases, Herbert Spencer, who writes: "Few diseases afflicting man have merited the attention and interest of medical scientists more than emphysema, yet despite its world-wide occurrence and its historic importance it attracted very little interest until the last two decades." "This account is timely because of the ever-increasing importance of emphysema in an aging population."

The writers patiently dispel the artless widespread view that this disease results simply from the obstruction to the outflow of inspired air so that the lungs blow up and burst like a balloon. Instead, the authors indicate how repeated insults slowly but inexorably destroy the beautiful lacy alveolar structures and reduce them to stained tatters. The authors' concept of pathogenesis centers on the slow destruction of alveolar walls and respiratory bronchioles by repeated bouts of inflammation. They emphasize how these delicate structures, uniquely suspended with dynamic tension in air, are so exquisitely vulnerable to destruction with small chance of repair. The resultant loss of radial traction on the walls of nonrespiratory bronchioles allows their deformity and collapse. This quite cogently is thought to be a major cause of the added obstructive component of emphysema.

Dr. Spencer credits these investigators with first forcefully documenting that tobacco smoking is a major factor in this destructive process in the most prevalent centrilobular form of emphysema. The authors suggest that the heterozygous form of Alpha 1 antitrypsin deficiency might be an important factor in the development of panlobular emphysema. In these patients also, smoking is associated with more advanced disease.

One author's passion for measurement - the true son of a mathematics professor - is much in evidence and dispels ambiguity with deceptive ease. The presentation is augmented by a copious use of excellent illustrations and photographs with selected diagrammatic figures for added clarity.

The authors' many Florida friends can experience an additional chauvinistic pleasure in reading such scholarly work done by colleagues. As usual, Charles C. Thomas has produced a beautiful book.

C. Merrill Whorton, M. D.
Jacksonville

Dr. Whorton is a practicing Pathologist at St. Vincent's Hospital, Jacksonville.

Drug Detectives

The University of Florida's Drug Information and Pharmacy Resource Center, which fields and answers all sorts of questions about drugs, recently observed its fifth anniversary.

Staffed by faculty and students of the UF College of Pharmacy, the DIPRC receives about 15 questions a day via toll-free WATS line. Practicing pharmacists are the most frequent users of the service, followed by physicians, nurses, dentists, veterinarians and others.

The service is available from 8:00 a.m. to 5:00 p.m. Monday through Friday. The toll-free number is 1-800-342-1106.

Books Received

Receipt of the following books is acknowledged. Medical readers interested in reviewing particular books are invited to address requests to the Book Review Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.

Healthy Pregnancy — The Yoga Way by Judi Thompson (Foreward by James C. Baker, M.D.). 148 Pages. Illustrated. Price \$3.95. Doubleday & Company, Inc., Garden City, New York, 1977.

How to Feed Your Hyperactive Child by Laura J. Stevens, George E. Stevens and Rosemary B. Stoner. 240 Pages. Price \$7.95. Doubleday & Company, Inc., Garden City, New York, 1977.

BT Behavior Therapy, Strategies for Solving Problems In Living by Spencer A. Rathus, Ph.D. and Jeffrey S. Nevid, Ph.D. 314 Pages. Illustrated. Price \$8.95. Garden City, New York, Doubleday & Company, 1977.

Apostles and Prophets, Medicine for Society's Ills by Frederick Eberson, Ph.D., M.D., Author of *Man Against Microbes*. 106 Pages. Illustrated. Price \$6.00. New York, Exposition Press, 1977.

Income Redistribution, edited by Colin D. Campbell. 267 Pages. Price \$4.75 (paperback) \$9.75 (cloth). Washington D.C., American Enterprise Institute for Public Policy Research, 1977.

Handbook for Differential Diagnosis of Neurologic Signs and Symptoms by Kenneth M. Heilman, M.D., Robert T. Watson, M.D. and Melvin Greer, M.D. 231 Pages. Illustrated. Price \$8.95. New York, Appleton-Century-Crofts, 1977.

Psychosomatic Aspects of Allergy by Claude A. Frazier, M.D. 257 Pages. Illustrated. New York, Van Nostrand Reinhold, 1977.

Stuttering Solved by Martin F. Schwartz, Ph.D. 186 Pages. Price \$3.50. New York, McGraw-Hill Paperbacks, 1976.

Controlling Health Care Costs, Strengthening the Private Sector's Hand by Clark C. Havighurst. 29 Pages. Price 35¢. Washington D.C., American Enterprise Institute, 1977.

Labor & Delivery, An Observer's Diary by Constance A. Bean with an introduction by Gerald Cohen, M.D. 203 Pages. Price \$7.95. Garden City, New York, Doubleday & Company, 1977.

Review of Physiological Chemistry, 16th Ed. by Harold A. Harper, Ph.D.; Victor W. Rodwell, Ph.D. and Peter A. Mayes, Ph.D., D.Sc. 681 Pages. Price \$13.00. Los Altos, Calif., Lange Medical Publications, 1977.

Child Health in the Community, edited by Ross G. Mitchell, M.D. 313 Pages. Price \$18. New York, Churchill Livingstone, 1977.

Medicine in the Tropics, Diagnostic Pathways in Clinical Medicine, An Epidemiological Approach to Clinical Problems by B. J. Essex. 173 Pages. Illustrated. Price \$9.95. New York, Churchill Livingstone, 1976.

The Rainbow

Joseph B. Pincus, M.D.

It has been said:

*"Light needs words
Its splendors to spell
But its inner rainbow
Only probing can tell."*

*Lights are sheaths
Be they of silver
or gold —
Vibrant veils
over mysteries
They hold.
Energy and mass —
Speed unsurpassed —
First to have left
Creation's nest.
But raindrops and snowflakes
Do their bonds dissolve.
To reveal hidden rainbows —
Not secrets to solve.*

*Your tapestries of word,
Your sculpture of phrase,
The search for beauty,
Its sparkle and grace.*

*These are the sources
That blend into light,
That covers rainbows
From superficial sight.*

*You were crowned with honor
With the scepter of praise —
But this was like daylight
Holding the hue of rays.*

*Those inner rainbows —
The poet in you —
This source of your greatness
Is known to few.*

*In the diadem
You wore today
I saw those rainbows —
More than praise can say.*

This poem by Dr. Pincus was written for and dedicated to Dr. A. Ashley Weech, of Gainesville, when he received the 1977 Howland Medal. Dr. Pincus, now retired, was formerly Professor of Pediatrics at the State University of Medicine at Brooklyn, N.Y.

MEETINGS

Approved by FMA Committee on Continuing Medical Education

September

Topics In Orthopedics #2, Sept. 6, Blake Memorial Hospital, Bradenton. For information: Allen R. Sklerov, M.D., 525 3rd St., E., Bradenton 33505.

Ocular Emergencies and Otolaryngology, Sept. 8, Mercy Hospital, Miami. For information: Salvador O'Neill, M.D., Mercy Hospital, Miami 33133.

Current Treatment of Hypertension, Sept. 14, Peace River Country Club, Bartow. For information: Bernard Briter, M.D., Director, Medical Education, University of South Florida, Tampa 33620.

Current Concepts in Gynecologic Oncology, Sept. 16-17, Casino Hotel, Pensacola Beach. For information: William H. McCaw, M.D., 1200 W. Leonard St., Pensacola 32501.

Basic Clinical Electrocardiography and Arrhythmia Management, Sept. 16-18, Orlando Hyatt House, Orlando. For information: William E. James, Ph.D., One Inverness Drive, Englewood, Colorado 80110.

Coronary Disease, Exercise Testing and Cardiac Rehabilitation, Sept. 16-18, Bahia Mar, Fort Lauderdale. For information: William E. James Ph.D., One Inverness Drive, Englewood, Colorado 80110.

Acute Cardiac Care, Sept. 28-30, Mt. Sinai Medical Center, Miami Beach. For information: Philip Samet, M.D., 4300 Alton Road, Miami 33140.

25th Annual Seminar, American Diabetes Association, Florida Affiliate, Sept. 29-Oct. 2, Don Caesar Resort Hotel, St. Petersburg.

Medical Aspects of Aging, Sept. 30-Oct. 1, Gainesville, Hilton, Gainesville.**

OCTOBER

Topics In Family Medicine, Oct. 3-7, Americana Hotel, Bal Harbour. For information: Elliott Podoll, M.D., P.O. Box 520875, Miami 33152.

Third Panamerican Seminar, Oct 3-7, Mount Sinai Medical Center, Miami Beach. For information: Office of CME, 4300 Alton Road, Miami Beach 33140.

*For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152, Tel. (305) 547-6716.

**For Information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143.

+For Information: Contact Theron A. Ebel, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2074.

Update of Diabetes, Oct. 6, University Health Center, Tallahassee. For information: Philip C. Rond, M.D., University Health Center, Tallahassee 32306.

Current Concepts and Treatment in Cerebrovascular Disease, Physiologic Basis for Central Nervous System Pacemakers and Current Concepts on Senility, Aging and Parkinson's Disease, Oct. 6-8, Naples Bath and Tennis Club, Naples. For information: Allan Herskowitz, M.D., 115 N.W. 167th St., Suite 302, North Miami Beach 33169.

Obstetrics and Gynecology Review Course, Oct. 8-14, Miami.*

Review Course on "Fundamental and Clinical Aspects of Internal Medicine," Oct. 9-22, Sheraton Four Ambassadors, Miami. For information: J. Bocles, M.D., Department of Medicine, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152.

Use and Abuse of Blood and Its Components, Oct. 11, Manatee Memorial Hospital, Bradenton. For information: Allen R. Sklerov, M.D., 525-3rd Street, East, Bradenton 33505.

Florida Urological Society annual fall meeting, Oct. 13-16, Ponte Vedra Club, Ponte Vedra. For information: Raymond J. Fitzpatrick, M.D., 706 S. W. 4th Ave., Gainesville 32601.

Florida Society of Internal Medicine and American College of Physicians, Florida Region, Oct. 14-16, Colony Beach and Tennis Resort, Long Boat Key.

Obstetrics and Gynecology Review Course: Pathology Section, Oct. 15-16, Miami.*

OB-GYN Culoscopy Course, Oct. 17-19, Miami.*

Common Skin Problems in the College Community, Oct. 20, University Health Center, Tallahassee. For information: Philip Rond, M.D., University Health Center, Tallahassee 32306.

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Oct. 24-29, Miami.*

Medico-Legal Aspects of Medicine, Oct. 27, University Health Center, Tallahassee. For information: Philip Rond, M.D., University Health Center, Tallahassee 32306.

Interstate Scientific Assembly, Oct 31-Nov. 3, Diplomat Hotel, Hollywood. For information: Alton Ochsner, M.D., Post Office Box 1109, Madison, Wisconsin 53701.

NOVEMBER

Venereal Disease: The Laboratory, Nov. 3, University Health Center, Tallahassee. For information: Philip Rond, M.D., University Health Center, Tallahassee 32306.

Fall Meeting of the Florida Society of Ophthalmology, Nov. 3-6, Sandpiper Bay, Port St. Lucie, Florida. For information: Susan Waits, Suite 400G, Barnett Bank Building, Tallahassee 32301.

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Nov. 7-12, Miami.*

Seventh George Papanicolaou Memorial Seminar, Nov. 9, Dallas, Texas. For information: George Ioannides, M.D., Dept. of Path., St. Francis Hospital, Miami Beach 33141.

Pars Plana Vitreous Surgery - The Miami Technique, Nov. 10-12, Miami.*

The Eye In Family Practice, Nov. 11-12, Miami.*

Knee Injuries and the College Student, Nov. 17, University Health Center, Tallahassee. For information: Philip Rond, M.D., University Health Center, Tallahassee 32306.

Clinical Application of the Intra-Aortic Balloon Pump, Nov. 25-27, Miami.*

DECEMBER

Laparoscopy: Diagnostic and Therapeutic Techniques, Dec. 1-3, Contemporary Resort Hotel, Lake Buena Vista. For information: H. Worth Boyce, Jr., M.D., 12901 North 30th St., Tampa 33612.

Basic Clinical Electrocardiography and Arrhythmia Management, Dec. 2-4, Royal Biscayne, Miami. For information: William E. James, Ph.D., One Inverness Drive, Englewood, Colorado 80110.

The Vitreous, Dec. 7-9, Miami.*

Pediatric Anesthesia, Dec. 8-11, Miami.*

Medical Surgical Seminar, Dec. 9-10, St. Francis Hospital, Miami Beach. For information: Lawrence R. Medoff, M.D., 250 West 63rd Street, Miami Beach 33141.

Intraocular Lenses, Dec. 12-15, Miami.*

Tutorial Courses of Instruction In Coronary Care for the Practicing Physician, Dec. 12-17, Miami.*

JANUARY

1978

Fifth Annual Symposium In Pediatric Nephrology: Current Concepts In Diagnosis and Management, Jan. 4-7, Miami.*

Fifteenth Annual Postgraduate Seminar In Anesthesiology, Jan. 5-8, Americana Hotel, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

Miami Winter Symposium, Jan. 9-13, Miami.*

Tutorial Courses of Instruction In Coronary Care for the Practicing Physician, Jan. 9-14, Miami.*

Third Annual Seminar, "Problems In Pediatric Radiology", Jan. 13-17, Miami.*

3rd Annual Seminar "Problems In Pediatric Radiology", Jan. 13-17, Sonesta Beach Hotel and Tennis Club, Key Biscayne.*

Post-Convention Seminar: Pediatric Radiology

Postconvention Seminar In Pediatric Radiology "Radiographic-Pathologic Correlation of Pediatric Diseases", Jan. 17-20, The Colony Beach and Tennis Resort, Sarasota.*

Art and Science In the Therapy of Difficult Problems In Surgery, Jan. 18-21, Miami.*

10th Annual Postgraduate Seminar In Pediatric & Adult Urology, Jan. 19-21, Carillon Hotel, Miami Beach. For information: Victor Politano, M.D., 3900 Northwest 79th Ave., Suite 469, Miami 33166.

Corneal and Plastic Ophthalmic Surgery and Diseases of the Eye, Jan. 22-27, Miami.*

3rd Annual Review and Recent Practical Advances In Pathology, Jan. 23-27, Miami.*

A Neurological Update: 1978, Jan. 23-27, Miami.*

Coronary Disease, Exercise, Testing and Cardiac Rehabilitation, Jan. 27-29, Orlando Hyatt House, Orlando. For information: William E. James, Ph.D., One Inverness Dr., Englewood, Colorado 80110.

Thirteenth Annual Scientific Assembly of the American Society of Contemporary Medicine and Surgery, Jan. 30-Feb. 3, Americana Hotel, Miami Beach. For information: John G. Bellows, M.D., 6 North Michigan Avenue, Chicago 60602.

FEBRUARY

23rd Central Florida Medical Meeting, Feb. 3-5, Contemporary Resort Hotel, Orlando. For information: Edward Ackerman, M.D., 800 West Morse Blvd., Winter Park 32789.

Fourth Annual Fall Conference In Anesthesiology, Feb. 4-11, Miami.*

OB-GYN Caribbean Seminar, Feb. 4-11, Miami.*

Florida Midwinter Seminar In Ophthalmology, Feb. 6-8, Miami.*

13th Annual "Internal Medicine 1978", Feb. 6-11, Miami.*

Florida Midwinter Seminar In Otolaryngology, Feb. 9-11, Miami.*

Principles of Practice Management, Feb. 12-18, Miami.*

MICROVASCULAR SURGERY COURSES

The Microsurgical Education Center in the Division of Neurological Surgery at the University of Florida is offering two microvascular surgery courses lasting three days for thoracic and cardiovascular surgeons. The courses will be held in November and December, 1977.

For registration and further course information, write:

Ms. Dianne Wright
Division of Neurological Surgery
Box J-265 Health Center
University of Florida
Gainesville, Florida 32610

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metolazone [Zaroxolyn] no doubt contributed to patient compliance."

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Recommended initial dosage in mild to moderate essential hypertension—2½ to 5 mg once daily

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2½-mg, 5-mg and 10-mg tablets

once-daily antihypertensive diuretic


Before prescribing, see complete prescribing information in the package insert, or in PDR, or available from your Pennwalt representative. The following is a brief summary. **Indications:** Zaroxolyn (metolazone) is an antihypertensive diuretic indicated for the management of mild to moderate essential hypertension as sole therapeutic agent and in the more severe forms of hypertension in conjunction with other antihypertensive agents. Also, edema associated with heart failure and renal disease. **Contraindications:** Anuria, hepatic coma or precoma, allergy or sensitivity to Zaroxolyn. Or, as a routine in otherwise healthy pregnant women. **Warnings:** In theory cross-allergy may occur in patients allergic to sulfonamide-derived drugs, thiazides or quinethazone. Hypokalemia may occur, and is a particular hazard in digitalized patients, dangerous or fatal arrhythmias may occur. Azotemia and hyperuricemia may be noted or precipitated. Considerable potentiation may occur when given concurrently with furosemide. When used concurrently with other antihypertensives, the dosage of the other agents should be reduced. Use with potassium-sparing diuretics may cause potassium retention and hyperkalemia. Administration to women of childbearing

age requires that potential benefits be weighed against possible hazards to the fetus. Zaroxolyn appears in the breast milk. Not for pediatric use. **Precautions:** Perform periodic examination of serum electrolytes, BUN, uric acid, and glucose. Observe patients for signs of fluid or electrolyte imbalance. These determinations are particularly important when there is excessive vomiting or diarrhea, or when parenteral fluids are administered. Patients treated with diuretics or corticosteroids are susceptible to potassium depletion. Caution should be observed when administering to patients with gout or hyperuricemia or those with severely impaired renal function. Hyperglycemia and glycosuria may occur in latent diabetes. Chloride deficit and hypochloremic alkalosis may occur. Orthostatic hypotension may occur. Dilutional hyponatremia may occur in edematous patients in hot weather. **Adverse Reactions:** Constipation, nausea, vomiting, anorexia, diarrhea, bloating, epigastric distress, intrahepatic cholestatic jaundice, hepatitis, syncope, dizziness, drowsiness, vertigo, headache, orthostatic hypotension, excessive volume depletion, hemoconcentration, venous thrombosis, palpitation, chest pain, leukopenia, urticaria, other skin rashes, dryness of mouth,

hypokalemia, hyponatremia, hypochloremia, hypochloremic alkalosis, hyperuricemia, hyperglycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasm, weakness, restlessness, chills, and acute gouty attacks. **Usual Initial Once-Daily Dosages:** mild to moderate essential hypertension—2½ to 5 mg; edema of cardiac failure—5 to 10 mg, edema of renal disease—5 to 20 mg. Dosage adjustment may be necessary during the course of therapy. **How Supplied:** Tablets, 2½, 5 and 10 mg

References:

- 1 Dornfeld L, Kane R. Metolazone in essential hypertension. The long-term clinical efficacy of a new diuretic. *Curr Ther Res* 18: 527-533, 1975
- 2 Data on file, Medical Department, Pennwalt Prescription Products

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UNIVERSITY OF MIAMI SCHOOL OF MEDICINE
DEPARTMENT OF INTERNAL MEDICINE

FOURTH ANNUAL REVIEW COURSE

"Fundamental and Clinical Aspects of Internal Medicine"

Sheraton-Four Ambassadors Hotel

Miami, Florida

October 9-22, 1977

Directors: William J. Harrington, M.D., Eric Reiss, M.D., and Neal S. Bricker, M.D.

Program Coordinator: Jose S. Bocles, M.D.

This course is designed primarily for physicians who are preparing for initial certification or recertification in internal medicine. It will provide an intensive survey of those aspects of internal medicine which should be familiar to internists qualified for certification. Pertinent basic and core information followed by a survey of recent clinical advances needed for effective patient care will be presented. Printed texts, references and self-assessment questionnaires will be provided to all registrants, and audio-visual teaching aids will be available for self-instruction and reinforcement. This course will end one week prior to the recertification examination of the American Board of Internal Medicine, thereby providing time for assimilation.

Schedule

Week I — October 10-15, 1977

October	10	Gastroenterology & Hepatology
"	11	Cardiology
"	12	Hypertension & Body Fluids
"	13	Nephrology
"	14	Endocrinology
"	15	Oncology & Genetics

Week II — October 17-22, 1977

October	17	Hematology
"	18	Infectious Diseases & Immunology
"	19	Rheumatology
"	20	Pulmonary Diseases
"	21	Clinical Pharmacology, Dermatology, Toxicology & Environmental Medicine
"	22	Neurology & Psychiatry

Supervised CME Activities: 84 Hours Credit

As an organization accredited for continuing medical education, the University of Miami School of Medicine certifies that this continuing medical education offering meets the criteria for 84 credit hours in Category I of the Physician's Recognition Award of the American Medical Association, provided it is used and completed as designed.

Self-Instructional Materials: 64 Hours Credit

As an organization accredited for continuing medical education, the University of Miami School of Medicine certifies that when these continuing medical education materials are used as directed, they meet the criteria for 64 hours of credit in Category I for the Physician's Recognition Award of the American Medical Association.

Registration Fees: Entire Course (Oct. 10-22) \$500
Week I (Oct. 10-15) \$300
Week II (Oct. 17-22) \$300
Per day (minimum of 3 days) \$ 70

Checks payable to: U/Miami Internal Medicine Review Course.

Minimum and maximum enrollment has been established for this course. Please register early. Registration is non-transferable.

In case of withdrawal, we require written notice before September 28, 1977. An administrative fee of \$25 will be charged for any refund made.

For information and application write to:

J. Bocles, M.D., Department of
Internal Medicine
University of Miami School of Medicine
P. O. Box 520875, Miami, Florida 33152
Phone: (305) 547-6063

*Includes tuition, set of 11 textbooks, use of audiovisual aids, library loan of T.V. tapes, cassette tapes and sets, and slides.

PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy—and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information

is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

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Physicians May Report Driver Impairment

Physicians may report with immunity physical or mental conditions that might affect a persons ability to drive a car, according to a legal opinion by FMA attorney John E. Thrasher.

Mr. Thrasher, in response to an inquiry, quoted a section of state law that specifically authorizes such reports to the Department of Highway Safety and Motor Vehicles.

The law states that such reports are confidential and no civil or criminal action may be brought against the physician making the report, Mr. Thrasher wrote.

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MIAMI, FLORIDA: G.P.—Seven man multispecialty, fee-for-service group is seeking a G.P. to join the group. Contact Mr. Jack White, 1025 E. 25th St., Hialeah, Florida 33013. Phone: (305) 696-0842.

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SPECIALISTS

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GASTROENTEROLOGIST AND ORTHOPEDIC SURGEON needed by multispecialty 20-man group in Aventura, North Miami Beach. This is a quality, fee-for-service group in private practice. Please visit our medical center and send curriculum vitae to The Aventura Medical Center, 2956 Aventura Boulevard, North Miami Beach, Florida 33180.

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Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psycho-

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tropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relation-

ship has not been established clinically.

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Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

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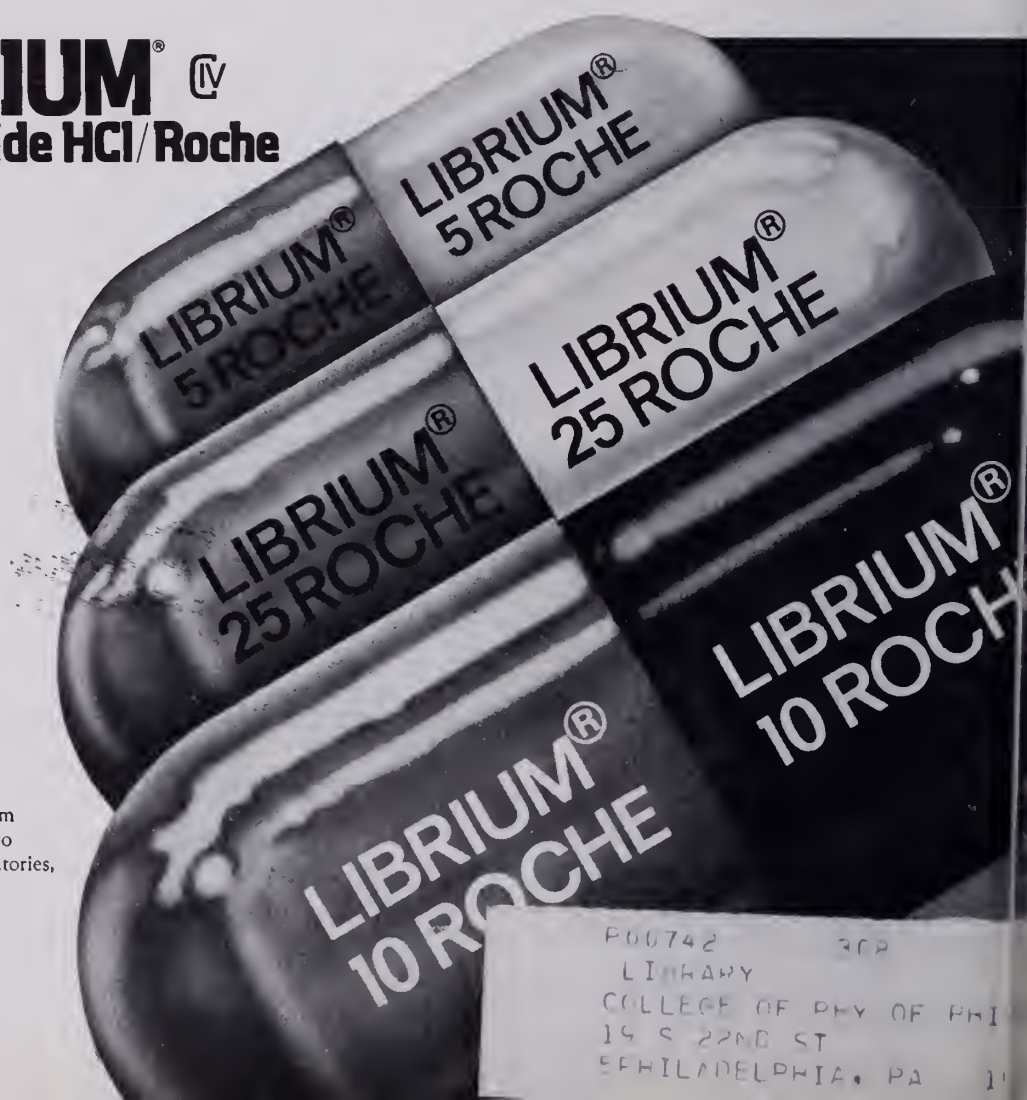
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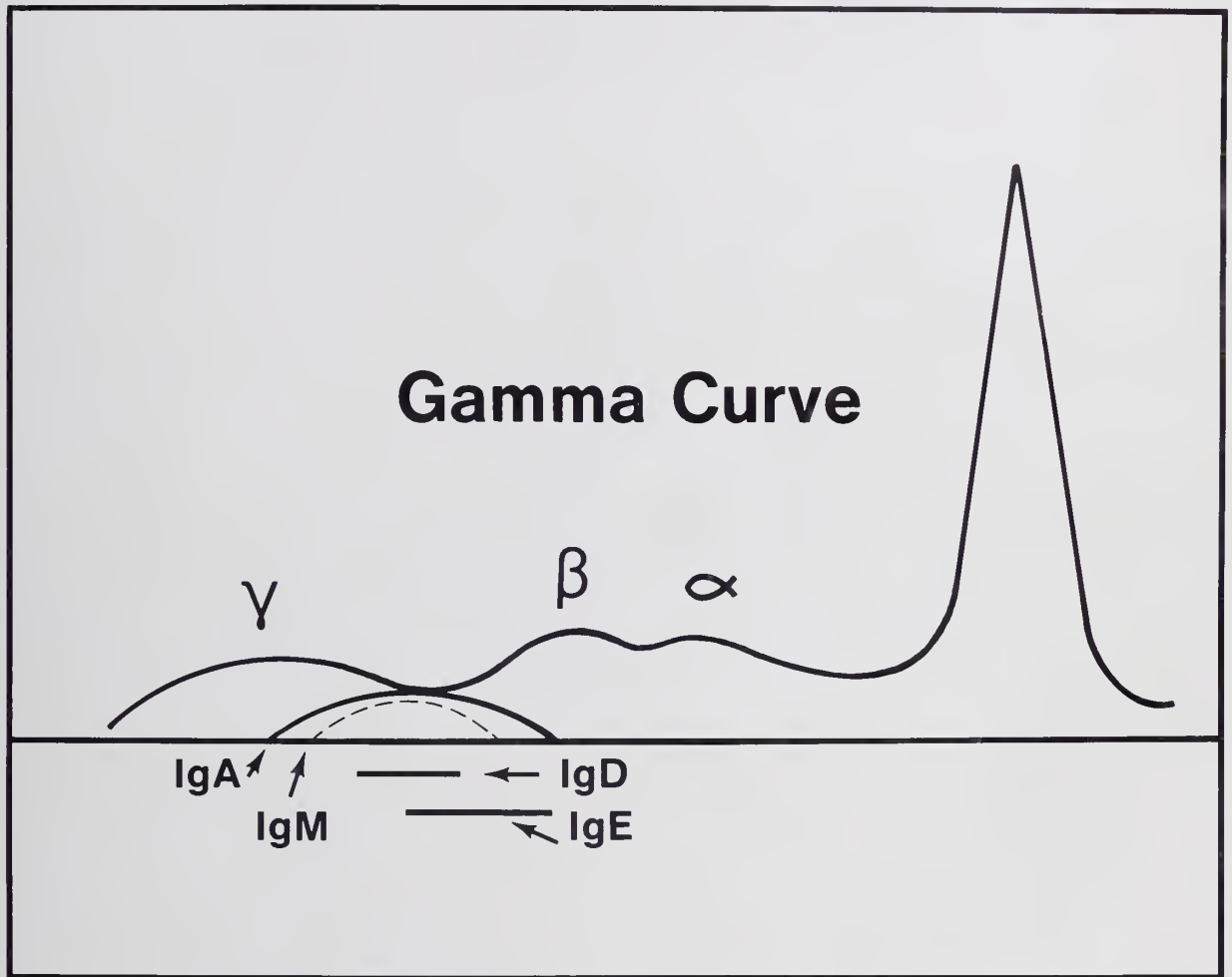
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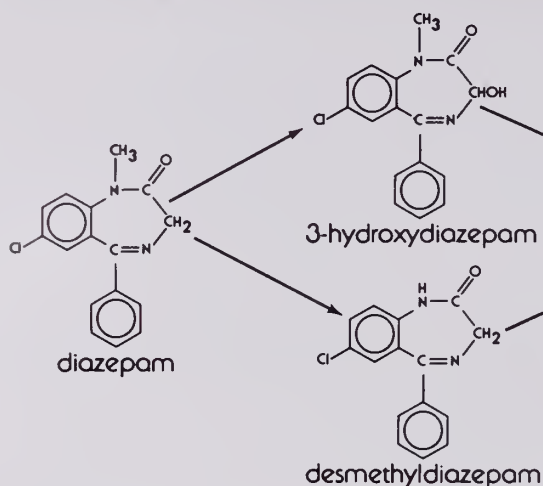


“Clinical Evaluation of the Immunologically Involved Patient” — See Page 633.

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Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma;

may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients.

Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.
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Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

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SEPTEMBER COVER — This figure, from Dr. Morton L. Hammond's article in this issue entitled "Clinical Evaluation of the Immunologically Involved Patient," is the gamma curve in the serum electrophoretic pattern.

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The Next Twenty Years

William B. Deal, M.D.

On September 12, 1977, another first year medical class begins the continuum of medical education at the University of Florida. The Class of 1981 is the twenty-first entering class and they will join nearly 3000 women and men who are: (a) currently enrolled as M.D. candidates, (b) members of the current housestaff, (c) College of Medicine alumni, and (d) Housestaff alumni.

This group of young people will be challenged with a burgeoning amount of scientific data throughout their professional careers. It is the responsibility of medical schools to provide the student with a framework of scientific information in a structured fashion in order to facilitate his/her acquisition of knowledge in a rather unstructured fashion after graduation. Without a strong framework, self-motivation for continuing education becomes difficult or even absent.

In the past twenty years our scientific knowledge has increased logarithmically. Few diseases are managed the same today as twenty years ago. Commonplace procedures in 1977 which are household words were only experimental if not just visions in 1957: kidney transplantation, microsurgery, total hip replacement, aminocentesis, computerized axial tomography, immunotherapy, marrow transplantation. New sub-

specialties have emerged as a result of new information concerning the mystery of new life: perinatology and neonatology. The successful management of psychiatric patients with psychoactive drugs has resulted in closing of chronic care psychiatric beds nationwide. Advances in tuberculosis therapy has virtually relegated the tuberculosis sanatoria to the medical history files. The list continues.

Undoubtedly, the practice of medicine will continue to change in the next twenty years. Acquisition and assimilation of new information can be consuming. As we progress scientifically to increase our competence, we must not de-emphasize compassion. Competence without compassion is to be abhorred. Compassion without competence is worthless. So the challenge for each of us in the next twenty years is to keep competence and compassion balanced. Montaigne in an essay said, "It is not a mind, it is not a body that we erect, but it is a man, and we must not make two parts of him."

- Dr. Deal, University of Florida College of Medicine, Gainesville 32610.

Dr. Deal, Acting Dean of the University of Florida College of Medicine, Gainesville.

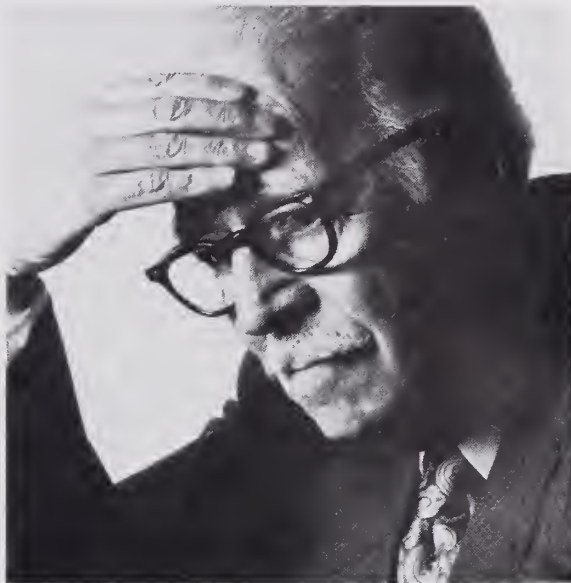
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and weakness, in addition to other signs of cerebral ischemia associated with postural hypotension may occasionally be seen. ISO-BID can act as a physiological antagonist to norepinephrine, histamine, acetylcholine and many other medications. An occasional patient may show marked sensitivity to the hypotensive effects of nitrite; severe responses (nausea, vomiting, weakness, restlessness, pallor, excessive sweating and collapse) can occur, even with the usual therapeutic dosage; alcohol may enhance this effect. A drug rash and/or exfoliative dermatitis is occasionally seen.

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1. Shane, S.J.: Canadian Family Physician, November 1973. 2. Lemberg, L.: Practical Cardiology, February 1976.



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Tuesday, January 31: CARDIOVASCULAR DISEASES (continued). Speakers: Leon Resnekov, Philip Samet, Bernard L. Segal, David Sheps, Ruey Sung, Henry Wagner, Jr. **HYPERTENSION** Chairman: John Laragh. Speakers: Frank Finnerty, Jr., James Hunt, Norman Kaplan, David Lowenthal, Robert Maronde. **PULMONARY DISEASES** Speakers: Maurice Segal, James Tennenbaum. **COSMETIC SURGERY** Chairman: Pierre Guibor. Speakers: Howard Beale, Crowell Beard, Richard Coburn, Frank Gillen, Robert Simons, Dowling Stough.

Wednesday, February 1: INFLAMMATORY BOWEL DISEASE Chairman: Joseph Kirsner. Speakers: Richard Farmer, Henry Janowitz, Martin Kalser, Burton Korelitz, Rene Menguy, Albert Weinfeld. **COMMON GASTROINTESTINAL PROBLEMS** Chairman: Arvey I. Rogers. Speakers: Jamie Barkin, Frank DeLand, Vicente Dinoso, Jr., Michael Levitt, Armand Littman, Albert Mendeloff, Daniel Paloyan, Herbert Sarett.

Thursday, February 2: CANCER Chairman: Joseph Painter. Speakers: Edward Beattie, Jr., William Cahan, Philip Exelby, Alfred Fracchia, Laurence Gardner, Ariel Hollinshead, Alfred Ketcham, Joe Levi, Alan Livingstone, Ralph Marcove, James Ozenberger, George Prout, Jr., Gerald Rosen, Charles Vogel, Horace Whiteley, Jr., C. Gordon Zubrod.

Friday, February 3: GENITOURINARY DISEASES Chairman: George Prout, Jr. Speakers: William Fair, T. W. Hensle, Gerald Mandell, Staffan Nordqvist, M. J. Vernon Smith, Louis Weinstein.

Completing the program will be a series of tutorial courses and workshops conducted by experts on: Cryosurgery, Endocrine Emergencies, The Management of Pain, The Pathogenesis and Management of Severe Acid-Base Abnormalities, Neuropsychiatric Manifestations of Systemic Disease, Sexual Function and Dysfunction, Beta-Adrenergic Blocking Agents, Biofeedback in Office Practice.

For Further Information and Complete Program, Write or Call:

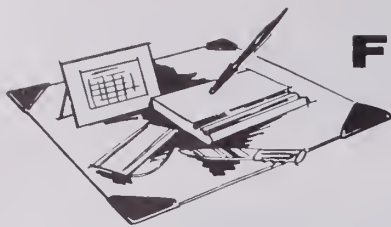
John G. Bellows M.D., Ph.D., Director

American Society of Contemporary Medicine and Surgery

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FROM THE EDITOR'S DESK

CPT

The state medical associations of Minnesota and Montana have endorsed the new fourth edition of AMA's **Current Procedural Terminology**. The work represents a comprehensive system for naming, coding and reporting medical procedures and services and provides a nationwide uniform language among physicians, patients and third parties.

* * * *

RETIREMENT

A literature resource center for retirement information is being organized by the AMA library and the American Retired Physicians Association. Ready this month, the center will contain articles on retirement taken mainly from medical journals.

* * * *

HIGH SCHOOL DEBATE

Reference kits with articles on malpractice, national health insurance and national health planning are being prepared by AMA for high school debate teams. Each state forensic league will choose one of the three topics for debate by high school teams during the coming school year.

* * * *

\$5,000 GRANT

AMA has awarded a grant of \$5,000 to the Council for the Advancement of Science Writing in support of the Nate Haseltine Fellowship Program in scientific writing. The grant will provide fellowships of up to \$1,500 a year for working journalists and journalism students.

* * * *

PSRO

HEW's revised draft guidelines concerning PSRO long term care review "go beyond the provision . . . of the prototypes contemplated by Congress and seek to establish a detailed and almost uniform system of operations which would govern nearly all local PSRO activities," the AMA claims. AMA strongly objected to HEW's preference for PSRO review of each patient to determine proper level of care and length of stay, and to assign respective levels of care and review dates for particular patients.

* * * *

ALCOHOLISM

AMA has published the third edition of its **Manual on Alcoholism**. The book presents an authoritative overview of the considerations involved in helping patients with alcohol problems.

* * * *

NEW AMA PRESIDENT

John H. Budd, M.D., of Cleveland, Ohio, was installed as the 132nd President of the American Medical Association at the AMA's Annual Convention in San Francisco in June. In his inaugural address, Dr. Budd said the AMA stands as "a citadel for the survival of voluntary action . . . as opposed to the expanding power of centralized government." He called on AMA to support "any rational and realistic means" of reducing health care expenses.

* * * *

INFORMATION CAMPAIGN

The AMA House of Delegates has ordered a "vigorous public information campaign" on all aspects of the health care system. The AMA Board

of Trustees was directed to provide state medical associations with a "detailed demonstration" of a program within 90 days. Earlier, the Board announced two public information programs — an expanded speakers bureau and "A Report to the American People on Health Care," to be included in national publications as an advertising insert.

* * * *

COMPREHENSIVE INSURANCE

The AMA House reaffirmed support of AMA's comprehensive health care insurance proposal as introduced in Congress and its "total opposition to the nationalization of the medical profession. In other actions, the House: reaffirmed its position that a medical resident is both a student and an employee under the National Labor Relations Act; approved opposition to the Administration's hospital cost containment legislation; and supported legislative or regulatory measures to permit continued marketing of saccharin with a warning label.

* * * *

FOREIGN MEDICAL GRADUATES

AMA has clarified its position on the immigration of foreign medical graduates to this country. In a letter to the Commissioner of Immigration and Naturalization, AMA proposed that preference granted FMGs for permanent U.S. residency be eliminated and that the Exchange Visitor Program be used as originally intended. Under that program, FMGs come to this country for additional training, then return to their own land. AMA said it had never advocated a cut-off of FMA immigration, but it believes the growth in the number of United States graduates, coupled with other factors, will eventually reduce this country's reliance on FMGs.

* * * *

IMMUNIZATION

Participants in HEW's second National Immunization Conference have called for a permanent National Commission on Immunization. The proposed commission would act as the government's main information source on immunization practice and would work to overcome public distrust growing out of the swine flu campaign.

HOSPITAL COST CONTROL

Control of hospital costs is one of the goals facing Robert Derzon, the recently appointed head of the new Health Care Financing Administration. Derzon has been director of hospitals and clinics for the University of California at San Francisco. Under HEW reorganization, the new HCFA will combine management and policy for Medicare and Medicaid.

* * * *

DIET CONFERENCE PAPERS

Papers presented at a 1975 conference on "Defined-Formula Diets for Medical Purposes" have been compiled and published by the AMA. The book includes sections on historical development and nutritional bases, physiologic and metabolic effects, and clinical roles of defined-formula diets. Price information may be obtained from the Order Department, AMA, 535 N. Dearborn St., Chicago, Ill. 60610.

* * * *

ACCREDITATION

The U.S. Office of Education's Advisory Committee on Accreditation has recommended that the Liaison Committee on Medical Education remain the accrediting body for medical schools for at least two more years. The recommendation was made to the Commissioner of Education over the opposition of the Federal Trade Commission. FTC's Bureau of Competition has charged that "the accreditation process could, at least theoretically, be influenced by AMA's economic interest." AMA occupies six seats on the 15-member LCME.

* * * *

RELATIVE VALUE STUDIES

The Federal Trade Commission has suggested that the California Medical Association voluntarily enter into a consent agreement prohibiting publication of its relative value studies. CMA said it is prepared to cease use of unit values but other portions of the consent agreements signed by several national specialty societies are not acceptable. The FTC has been looking at the RVS for some time but has made no formal charges.

The Editor

Our new Medical Necessity Program has two worthy goals:

- (1) To help contain costs.**
- (2) To upgrade medical care.**

This program initially identifies 28 surgical and diagnostic procedures which will not be paid routinely by Blue Shield. All pertinent claims will be reviewed for medical necessity and covered only when a clear need can be proven.

Following is a list identifying the 28 surgical and diagnostic procedures:

1. Ligation of Internal Mammary Arteries, Unilateral or Bilateral
2. Radical Hemorrhoidectomy, Whitehead Type
3. Omentopexy — Portal Obstruction
4. Kidney Decapsulation, Unilateral and Bilateral
5. Perirenal Insufflation
6. Nephropexy
7. Circumcision, Female
8. Hysterotomy
9. Supracervical Hysterectomy
10. Uterine Suspension
11. Uterine Suspension with Presacral Sympathectomy
12. Hypogastric or Presacral Neurectomy
13. Fascia Lata by Stripper — when used to treat lower back pain
14. Fascia Lata by Incision — when used to treat lower back pain
15. Ligation of Femoral Vein, Unilateral and Bilateral — when used to treat Post Phlebitic Syndrome
16. Excision of Carotid Body Tumor — when used to treat Asthma
17. Sympathectomy, Thoracolumbar, Unilateral or Bilateral — when used to treat Hypertension
18. Sympathectomy, Lumbar — when used to treat Hypertension
19. Basal Metabolic Rate — BMR
20. Protein Bound Iodine — PBI
21. Icterus Index
22. Ballistocardiogram — BCG
23. Phonocardiogram with Interpretation and Report
24. Angiocardiology, using Carbon Dioxide, Supervision and Interpretation Only
25. Angiocardiology, Single Plane, Supervision and Interpretation Only, in Conjunction with Cineradiography
26. Angiocardiology, Multi-Plane, Supervision and Interpretation Only, in Conjunction with Cineradiography
27. Angiography — Coronary, Unilateral, Selective Injection, Supervision and Interpretation Only, Single View unless in an Emergency
28. Angiography Extremity

This program was developed in cooperation with The American College of Physicians, The American College of Surgeons and The American College of Radiology. We ask your support in making our Medical Necessity Program 100% effective.*

*A claims review by The Florida Plan indicated that most of the procedures were already being screened for medical need and few of the services in question were being performed in Florida.



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Brief Summary

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Indications:

Streptococcus pyogenes (Group A beta hemolytic streptococcus)—Upper and lower respiratory tract infections, skin, and soft tissue infections of mild to moderate severity, where oral medication is preferred. Therapy should be continued for 10 days.

Alpha-hemolytic streptococci (viridans group)—Short-term prophylaxis of bacterial endocarditis prior to dental or other operative procedures in patients with a history of rheumatic fever or congenital heart disease who are hypersensitive to penicillin.

S. aureus—Acute infections of skin and soft tissue of mild to moderate severity. Resistant organisms may emerge during treatment.

S. pneumoniae (*D. pneumoniae*)—Upper and lower respiratory tract infections of mild to moderate degree.

M. pneumoniae—For respiratory infections due to this organism.

Hemophilus influenzae: For upper respiratory tract infections of mild to moderate severity when used concomitantly with adequate doses of sulfonamides. Not all strains of this organism are susceptible at the erythromycin concentrations ordinarily achieved (see appropriate sulfonamide labeling for prescribing information).

Treponema pallidum—As an alternate treatment in patients allergic to penicillin.

C. diphtheriae and *C. minutissimum*—As an adjunct to antitoxin. In the treatment of erythrasma.

Entamoeba histolytica—In the treatment of intestinal amebiasis.

L. monocytogenes—Infections due to this organism.

Establish susceptibility of pathogens to erythromycin, particularly when *S. aureus* is isolated.

Contraindications:

Known hypersensitivity to erythromycin.

Warnings:

Safety for use in pregnancy has not been established.

Precautions:

Exercise caution in administering to patients with impaired hepatic function. During prolonged or repeated therapy, there is a possibility of overgrowth of non-susceptible bacteria or fungi. Surgical procedures should be performed when indicated.

Adverse Reactions:

Dose-related abdominal cramping and discomfort. Nausea, vomiting, and diarrhea infrequently occur. Mild allergic reactions such as urticaria and other skin rashes may occur. Serious allergic reactions, including anaphylaxis, have been reported.



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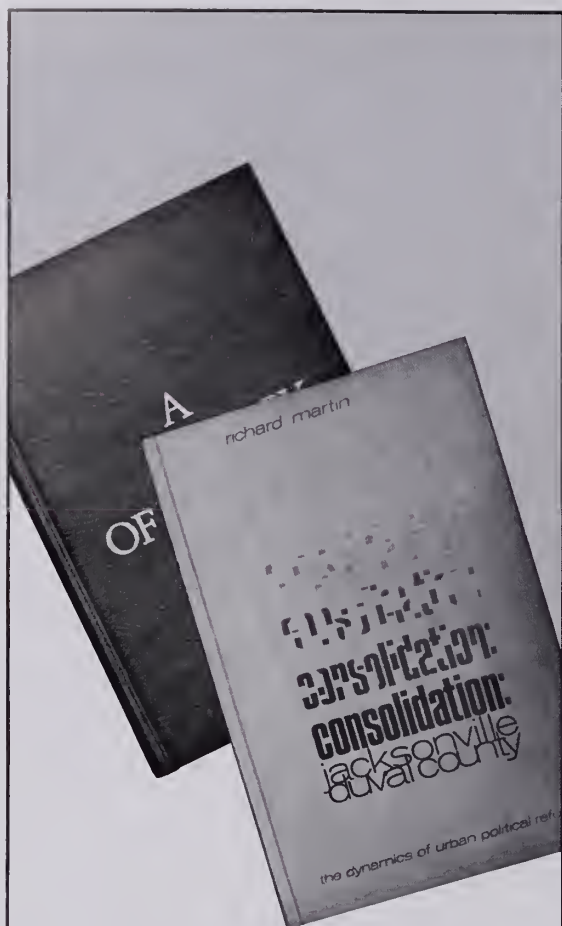
Important for patients who can better
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Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 µg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

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Please see brief summary of prescribing information on facing page.

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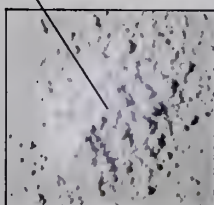


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References: 1. Goodman, L.S., and Gilman, A., eds.: The Pharmacological Basis of Therapeutics, Fifth Edition. New York, The Macmillan Company, 1975 (a) p. 335, (b) p. 336, (c) p. 344. 2. Eden, A.M.: Am. J. Dis. Child. 114:284-287 (Sept.) 1967. 3. Mintz, A.A.: J. Ky. Acad. Gen. Pract. 5:26-31 (Jan.) 1959. 4. Colgan, M.T., and Mintz, A.A.: J. Pediatr. 50:552-555 (May) 1957. 5. Saunders, D.C.: Practitioner 183:335-338 (Sept.) 1959. 6. Reuter, S.H., and Montgomery, W.W.: Arch. Otolaryngol. 80:214-217 (Aug.) 1964. © McN 1977

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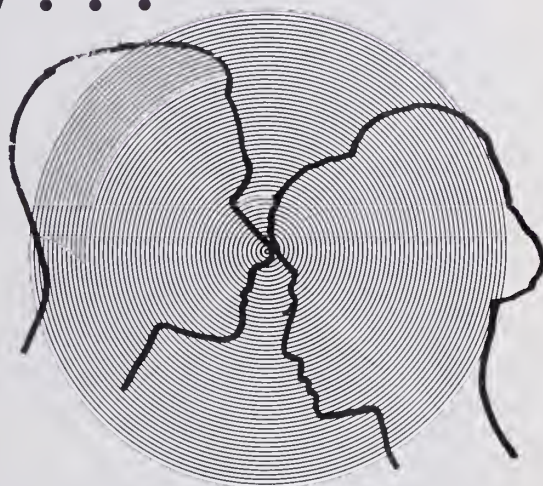
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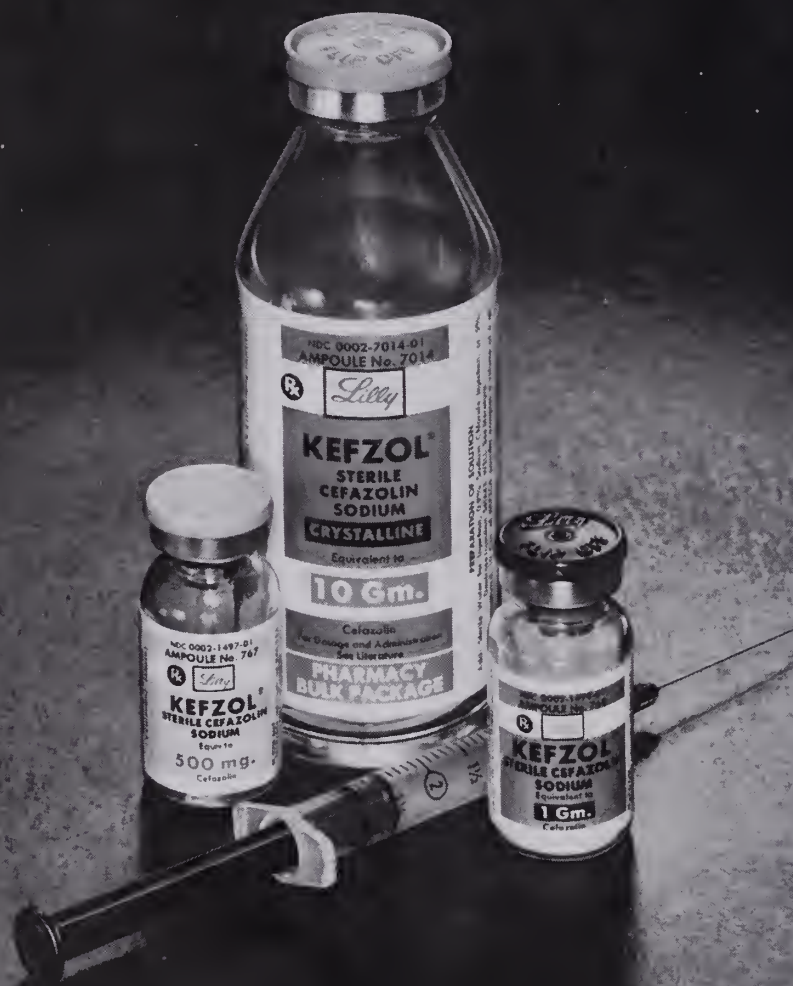
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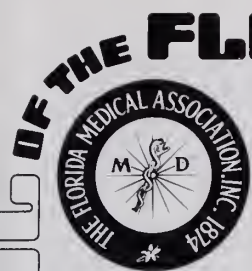
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"Clinical Evaluation of the Immunologically Involved Patient"

Part I

Morton L. Hammond, M.D.

ABSTRACT: This article presents background information related to development of cells that participate in the immune response (T, B, and phagocytic), mediators that are generated to effect the immune response (immunoglobulins, T cell mediators, complement), and their function. A classification of immunologic disorders is presented with reference to mechanisms, mediators, and examples of each.

Laboratory procedures are described to aid in delineation of the various disorders (precipitin test, immunoelectrophoresis, agglutination techniques, labeling procedures both fluorescent and radioactive, lymphocyte transformation, rosetting, etc).

The clinical approach then is presented with reference to particular details of history and laboratory data required, and specific tests recommended to establish the status of each immunologic system or function (deficiency states, phagocytic or complement aberration, disorders of class 1-4 type), and finally a check list of diseases, cross referenced with laboratory procedures that would serve as a guide to study of these disorders.

Because of the rapid advance of knowledge in immunology in the last ten years, many practicing physicians are encountering an almost insurmountable task of acquiring and organizing the new data. They may face a problem involving immune mechanisms with a mixture of frustration and confusion. This paper attempts to clarify the principles of diagnosis available today.

The function of the immune system is to recognize agents that might be damaging to the body

and to neutralize these agents, thereby maintaining the internal metabolic environment in a steady state. The mechanisms by which this is accomplished is through activation of humoral, cellular, and phagocytic defenses.

Cellular System of Immunologic Control

Lymphocytic System

The lymphocyte is at the core of this defense. It may be of some interest that, in the aggregate, this is a rather formidable "organ." All lymphocytes in the systems would probably occupy a mass about the size of the liver.

Development of the lymphoid system occurs along two independent pathways leading to functionally and morphologically distinct populations of immunocompetent cells.¹

Some lymphocytes migrate from the bone marrow to the thymus for processing and are destined to become "T" cells.² The "T" refers to thymus. Others which pass through lymphoid tissue (probably Peyer's patches) are the "B" cells. Peyer's patches are analogous to gut-associated lymphoid tissue in the chicken called the bursa, hence the "B" or bursal cell.

The T cells eventually constitute about 70% to 80% of the circulating pool of lymphocytes and those that are found in the lymph nodes occupy the subcortical or paracortical area for the most part.³ These cells function as mediators of cellular immunity in contradistinction to humoral immunity and are active in such functions as tuberculin sensitivity, graft rejection, resistance to some virus and

Fungus infections, tumor surveillance, delayed contact sensitivities, immunologic memory, and autoimmune disorders.⁴⁻⁶ They are morphologically identical to other small lymphocytes by light microscopy.

The T cell is identified by its ability to form a cluster of cells called "rosettes" when exposed to sheep erythrocytes. B cells, too, can form a rosette, however, this can occur only if the cell is sensitized and has acquired a complement marker.⁷ The T cell was considered recognizable by electron microscopy in that it was said to be devoid of villous projections on the surface and hence "bald," in contrast to the "B" lymphocyte which was said to have many villi. This is no longer acceptable as various populations of B and T cells can resemble each other under electron microscopy.⁸

The T cell, once stimulated, has a wide range of effects. The manner in which this is accomplished is not entirely clear, but certain soluble mediators to T cell functions are undoubtedly produced. Activated T cells, for instance, encourage through one of these mediators the accumulation of eosinophils and this factor, whatever it may be, is called the eosinophilic chemotactic factor (ECF).⁹

Macrophages, when accumulated in a capillary tube, have a tendency to migrate out to form a tuft at the outlet. Activated lymphocytes produce a substance that prevents this from occurring called the migration inhibition factor (MIF).¹⁰

In like manner, the T cell produces interferon, cytotoxic factor, macrophage chemotactic factor, macrophage activating factor, blastogenic factor, permeability factor, transfer factor, neutrophil chemotactic factor and others.¹¹ The cell also suppresses B cell activity, and there also has been demonstrated a helper function; the depressor cell and the helper cell orchestrating B cell function.^{12,13}

When activated by specific antigen, the B cell becomes the plasma cell which in turn is the source of immunoglobulin, a component of serum and the major line of defense against bacterial infection. The B cells in association with the helper function of the T cell produce a variety of immunoglobulin types which are differentiated according to the weight of the molecule, its electrophoretic mobility, antigenic differences, etc.¹⁴ They are variously termed IgG, IgA, IgM, IgD and IgE.

These various globulins can be measured as to quantity and quality. Quantitation is valuable in the diagnosis of deficiency states and changes associated with diseases such as primary biliary cirrhosis and rheumatoid arthritis. Immunoelectro-

phoresis of immunoglobulin, on the other hand, is useful in recognition of monoclonal-type protein seen in such conditions as multiple myeloma, Waldenstrom's macroglobulinemia, amyloidosis and malignancy.

Immunoglobulin Classes

The IgG class of antibody accounts for about 80% of serum immunoglobulin.¹⁵ It can cross the placenta to provide maternal antibody to the fetus and thereby protection to the newborn child for the first six months. The IgG level in serum varies with age; therefore, a decision as to whether or not hypogammaglobulinemia is present requires correlation to age, and standard charts are available for this purpose.¹⁶ In the serum electrophoretic pattern, these antibody types and subtypes make up the bulk of the area that is reflected as the gamma curve as seen in Figure 1. Deficiencies of IgG are associated with poor resistance to infection, particularly pyogenic infections such as sinusitis, pneumonia and progressive bronchiectasis.

IgM has an electrophoretic mobility that corresponds to the beta 2 globulins with some overlap into the gamma area. This is the first antibody class formed in the unborn infant and is, therefore, of some value in determining prenatal infections. Cord blood assays for specific IgM antibodies against various infections such as syphilis and cytomegalic virus are now possible. Because of its large size, this immunoglobulin remains in the vascular space and may attain high levels in chronic infection. Another important clinical characteristic is that it is the predominant antibody naturally produced against blood groups, accounting for ABO blood types.¹⁷

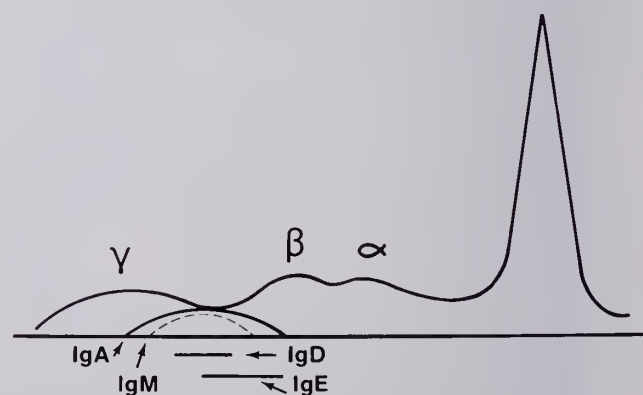


Figure 1

IgA is a beta 2 globulin. Serum IgA antibody differs from secretory IgA antibody in that the latter is a paired one, or a dimer. In its migration to the surface of the epithelial cell it picks up a secretory component.¹⁸ The serum IgA level and secretory IgA level do not necessarily correlate. It is safe to say that if there is serum IgA there will be secretory IgA. However, there may be no serum IgA yet normal secretory IgA levels. Finally, if there is no secretory IgA, there will be no serum IgA.¹⁹

A number of people are deficient in this antibody type (1 in 700), yet appear to be in good health. It is only now being recognized over the long term that these people have a higher incidence of immunologic disease than the normal population. In addition, those who have absent rather than low IgA levels have the capability to make anti-IgA antibodies and are at extra risk to transfusion reactions or reactions to gammaglobulin.²⁰ Some secretory IgA bathes body surfaces as in nasopharyngeal and GI tract, and is found in tears and urinary secretions.²¹ It has been postulated that secretory IgA offers protection against pathogens that invade the host through mucous membrane. This is demonstrated best, perhaps, by comparison of the type of immunity offered by the Salk and Sabin polio vaccines. The Salk elicits an IgG antibody that protects the individual from systemic infection but does not prevent the colonization of the mucosa by virus. The Sabin, on the other hand, elicits secretory IgA antibody protection against mucous membrane colonization and not only infection but the carrier state is avoided.²²

IgD is present in very small amounts and its function has not yet been identified. A recent study demonstrated that the B lymphocyte requires IgD and IgM on the cell surface as a precondition for transformation to plasma cell.²³

IgE is present in minute amounts as a rule but is often present in significantly larger amounts in allergic people.²⁴ It is the skin sensitizing antibody previously identified as "reagin" in allergic literature. This globulin has a propensity to attach to mast cells and when stimulated by specific antigen the involved mast cell is in turn stimulated to produce mediators of the allergic reaction such as histamine, eosinophilic chemotactic factor, slow reacting substance of anaphylaxis (SRSA) and prothrombin activating factor. These mediators of T and B cell functions are the "nuts and bolts" of immunology.

Although each of these immunocompetent T and B cells are given a clearly defined function, it is

apparent that there is considerable overlap and interdependence.

Complement

In order to evaluate immunologic activity it is also necessary to understand something of the nature and biologic activity of other component parts of the system. I have already reviewed the cell system involved, the mediators produced, and now will consider the complement and phagocytic systems.

Complement is an array of serum proteins, teleologically designed to assist in destruction or removal of materials recognized by the body defenses as noxious. The complement system interacts with white blood cells to enhance chemotaxis, phagocytosis, and lysis, as well as altered vascular permeability. Such proteins (labeled C1, C2, C3, etc.), once activated, act in sequence much as the blood clotting mechanism does, one step leading to another through the so-called "complement cascade."²⁵ The sequence is not numerical because components were numbered in order of discovery rather than function. Therefore, the reaction sequence is C1, C4, C2, C3, and from there on in numerical sequence.

One mechanism by which the system is activated is by some type of antigen-antibody union. Should some IgG (subtypes 1 and 3) or IgM antibody join an antigen as in an antigen-antibody complex, complement may be activated and tissue damage may be effected at the point of complex deposition (type III Gell and Coombs reaction). Once activated, C1 acts upon C4 and that upon C2 and thereupon C3 in that order. A C1 esterase inhibitor keeps this process in check under ordinary circumstances and prevents C1 from casual activation. Should the reaction progress from activation of C1 through C3, a vasoactive substance is released in surrounding fluid. One of these fragments is a large one, labeled C3b. The smaller fragment is labeled C3a and is an anaphylatoxin (Fig. 2). This has the capacity to cause mast cells to release histamine and is chemotactic as well as for polymorphonuclear leukocytes and eosinophils.²⁶ C5a further on in the sequence is similarly an anaphylatoxin but is chemotactic for polymorphonuclear and mononuclear cells.²⁶ As the sequence proceeds, it goes on to the lysis of cells. The larger fragment produced at C3 (C3b) when in contact with an antigen-antibody complex renders that complex immunologically "sticky" and is then able to adhere to the mem-

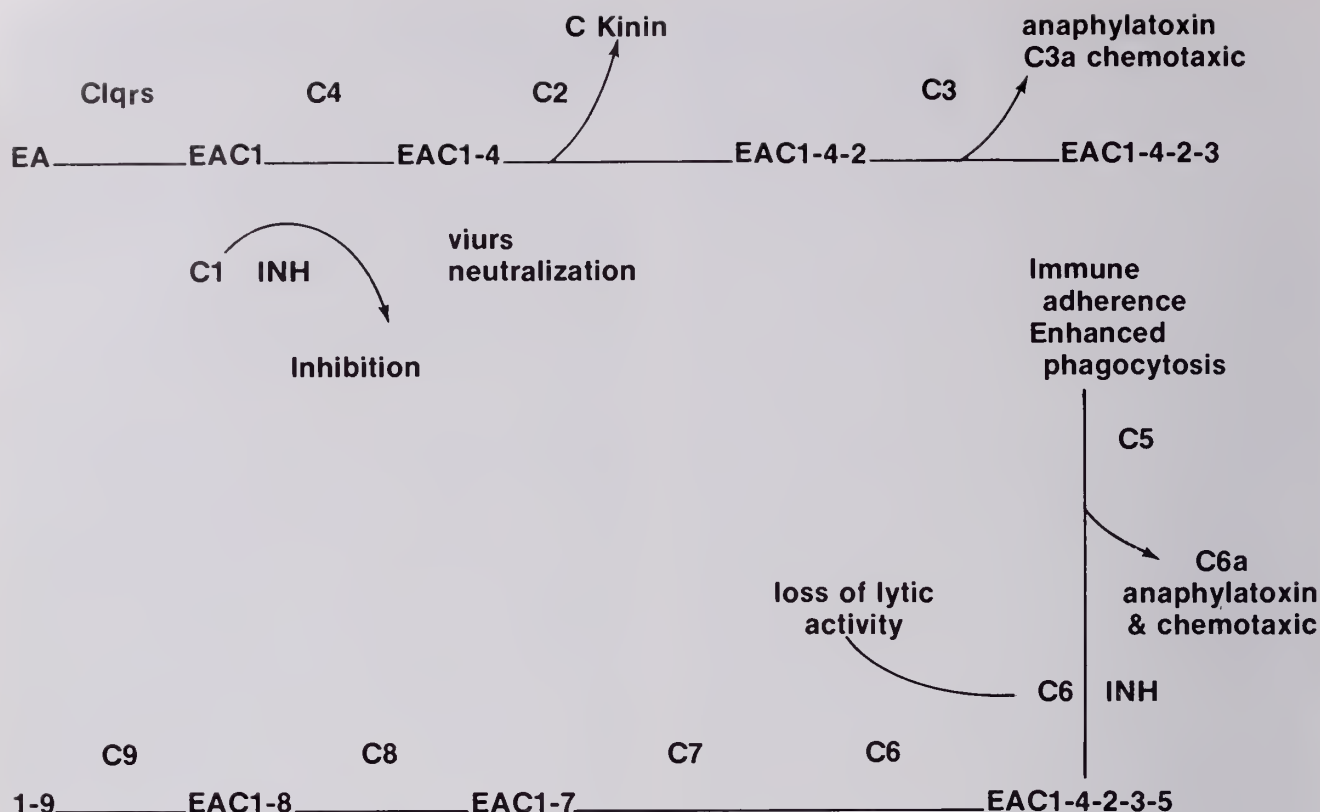


Figure 2

brane of phagocytic cells. This is a positive protective reaction (opsonization) facilitating phagocytosis.²⁵

It serves no purpose to describe the remainder of the complement cascade to accomplish sufficient understanding of its biologic activity. It is very important, however, to realize that there is an "alternate pathway" of activation of complement that is not dependent on antibody.²⁷ This is the so-called properdin pathway. Many materials will activate this system including inulin, dextran, viral and bacterial products and IgA.²⁵ Activated properdin yields a small molecule (similar to C1 esterase) called factor D which when activated acts on a second protein (similar to C4) called factor B which is then in turn activated. This plus C3b of the classic cascade is acted upon, and the complement system is now self-perpetuated.^{25,28}

Disorders in which complement plays a part include chronic recurrent infection, lupus erythematosus, chronic diarrhea, ataxia teleangiectasia, Klinefelter syndrome, and many others. Only some of these conditions are deficiency states. A very important although rare defect of the complement system, however, involves C1 esterase inhibitor in its

presence or activity. This is associated with hereditary angioedema, a life-threatening disorder. The reason for activation of C1 is not clear in this condition, but because the inhibitor is not present or is nonfunctional the process goes on to C3 activation and consequent vascular effects. Other inhibitors and inactivators have been described including those of C3, C3a, C6.²⁵

There are also acquired aberrations of complement fixation such as in lymphosarcoma where C1 inhibitor is at a low functional level and a clinical syndrome similar to hereditary angioedema results. Immune complex diseases and type II disorders (discussed later) similarly activate complement.²⁵ Systemic lupus erythematosus, rheumatic fever, bacterial endocarditis, some forms of nephritis, malaria, syphilis, vasculitis, arthritis, hepatitis, hypersensitivity angitis and Goodpasture's syndrome, for example, are other disease states where complement has been implicated. In allergy, some patients have abnormal C4 levels and low C3 levels have been correlated with what has been called "intrinsic asthma." This has not been proved but the implication is that some asthma is IgG mediated disease.

One can measure individual C3 and C4 levels by means of immunodiffusion techniques. The total complement activity can also be measured by means of a hemolytic assay, the CH50 level. This latter measurement, when low, indicates an imperfectly functioning complement system. If the result is normal, however, it does not rule out individual complement activity defects, because even with partial function of any given complement component the total system may still function adequately. In this assay, the titre refers to the dilution of fresh serum that will lyse 50% of a population of sensitized (antibody coated) sheep cells.²⁵

Phagocytes

This is the most primitive of our protective functions. There are three types of phagocytes: macrophages, polymorphonuclear cells, and eosinophils.²⁹ The monocyte is a circulating form of the macrophage. The phagocytic cell ingests particulate matter by invagination and engulfment. The energy for this function is derived from glycolysis with attendant increase in CO2 release. Following ingestion, there is a shift of metabolism to the hexose monophosphate shunt with increase in hydrogen peroxide production and a drop in PH. This, in association with lysosomal myeloperoxidase and halide ions, kills bacteria. On a clinical level, defects in this

system account for a condition in children called chronic granulomatous disease^{30,31} as well as generalized susceptibility to infection.

Immune Disease States

Symptoms and Classification

In order to establish some degree of coherence in immunology, a classification of humoral and cellular immunologic reactions based on reactivity of immunoglobulins and T cell (other than in deficiency diseases) has been presented by Gell and Coombs.³² This serves to help organize some of the major reactions types. However, it should be recognized as flexible, and that it can be used only as a general framework for understanding, for the reason that various conditions involve two groups and some conditions do not lend themselves to this classification at all. It classifies diseases in four types as is reproduced in Table 1.³³

Some pertinent data concerning each category as well as a discussion of deficiency diseases is necessary to approach these immunologic disorders at a clinical level.

Type I Reactions and Characteristics

Type I refers to the immunologic reaction that we consider characteristic of clinical allergy. The

Table 1

TYPE	I ANAPHYLACTIC	II CYTOTOXIC	III COMPLEX MEDIATED	IV CELL MEDIATED
Antibody mediating the re-action	Homocytotropic IgE antibody, (mast cell binding)	Humoral IgG antibody + complement	Humoral IgG	"T" lymphocytes & lymphokines
Antigen	Usually exo- genous (such as dust, mold pollen)	Cell surface	Extracellular aggregate	Extracellular cell surface
Response to skin test (time) (histology)	Wheat & flare 30 min. Edema eosinophils		Erythema edema 3-8 hours Inflammation mostly by polys	Erythema & induration 24-72 hours Inflammation mostly mononuclear
Examples of aberration of function	Atopy (asthma, urticaria, allergic rhinitis, etc.)	Transfusion reactions, hemolytic diseases of newborn, autoimmune hemolytic anemia, Goodpasture's syndrome, auto- immune agranu- locytosis, thyroiditis, thrombocytopenic purpura, etc.	Serum sickness, Rheumatoid arthritis, postviral nephritis, farmers' lung, lupus & periarteritis	Tuberculous cavitation, graft rejection, contact dermatitis, susceptibility to cancer

participants in this reaction are IgE and its target cell, the mast or basophil. These cells are found in abundance particularly in the skin and peribronchial tissues and have many cytoplasmic granules which are the reservoir of vasoactive amines such as histamine.

IgE attaches to these mast cells and when the cell with its "homocytotropic" antibody is exposed to its specific antigen, the cell is activated to discharge the mediators of the allergic reaction; that is, histamine, eosinophilic chemotactic factors (ECT), slow reacting substance-A (SRSA) and others.³¹ Only the histamine and ECT are preformed and already present in the cell.^{35,36} The mediators referred to are then responsible for the clinical symptoms of allergy, be it nasal, asthma, or urticaria. The laboratory procedures that apply to this category of disease include measurement of IgE antibody by skin test or RAST test and by studies of histamine release, immunodiffusion and others, all to be discussed later.

Type II Reactions and Characteristics

Type II reactions are the second type of immunologic injury referred to in the Gell and Coombs classification. The associated antibody is IgG. The reaction involves tissue antigen, for example, red blood cells, renal tissue, or vascular bed; hence the antibody is termed cytotoxic. The mechanism of injury in this class of reaction involves the participation of complement which facilitates tissue destruction and phagocytosis.³⁷

This class of disorder is operative in situations where a tissue by some mechanism (perhaps viral, drug, transfusion) is altered and recognized as somewhat different than self. IgG antibody is formed against such tissue and binds with it. In the presence of complement this tissue is then damaged or destroyed. Such a mechanism is seen in conditions such as Goodpasture's syndrome (where the basement membrane of both lungs and kidneys are attacked), chronic glomerulonephritis, insulin resistance, autoimmune hemolytic anemia, thrombocytopenic purpura, aggranulocytosis, vascular purpura and indeed any condition where any type of tissue is marked, through alteration or similarity in the challenging antigen, for sensitivity reactions. Fluorescent antibody studies show linear smooth deposition of antibody in the affected tissue in contrast to lumpy deposits found in type III reactions.³⁸

Type III Reactions and Characteristics

Type III reactions are characterized as "immune

complex" reactions. This refers to the fact that the active antibody (an IgG type) joins with the antigen and this "complex" now deposits in some particular site in the body. There is then an accumulation of the cellular components of inflammation, first polymorphonuclear cells then, after eight hours more or less, the gradual accumulation of mononuclear cells.³⁹ This is descriptive of the Arthus reaction which is the classic type III. In this classification of disorder, complement is generally enlisted in the reaction with destruction of tissue. A peculiarity of type III can be demonstrated with the fluorescent antibody technique which shows the antigen-antibody deposits in the basement membrane of the kidney to be a "lumpy" rather than smooth as would be the case in type II reaction.³⁸ Some of the clinical situations where type III reactions may occur is in serum disease, systemic lupus erythematosus (DNA, anti-DNA), rheumatoid arthritis³⁹ and periarteritis (where Australian antigen has been demonstrated in complexes).⁴⁰ Hypersensitivity pneumonitis has been considered a type III illness but other mechanisms (type IV) are also involved.⁴¹ The antigen responsible may be derived from molds (a variety of thermophilic actinomyces),⁴² insect animal emanations (pigeon droppings, etc.).⁴³ Confusion as to classification of these pneumonitides occurs because despite the presence of precipitating antibody, and the Arthus reaction, there has been no demonstration by immunofluorescence of immune complex deposition.

Type IV Reaction and Characteristics

Type IV is cellular or delayed hypersensitivity. This can be demonstrated by injection of tuberculin or mumps antigen into the skin and 24-48 hours later (in sensitized people) there will be development of an inflammatory reaction. This is a local delayed hypersensitivity response, but there may be systemic reactions as well.

Delayed hypersensitivity is produced by infectious agents of tuberculosis, of histoplasmosis, a number of proteins and by simple chemicals that are in combination with protein (haptens). The delayed reaction is involved in such conditions as tuberculosis, contact dermatitis, tumor susceptibility, graft rejection, etc.

The cellular response to this reaction is predominantly mononuclear. The mechanism of development of this type of sensitivity does not depend upon humoral B cell components but upon the T cell. Transfer to nonsensitive animals, for instance,

cannot be accomplished with serum but with cells.¹⁵ (11-p57). As one would expect, any situation where T cells are deficient would account for defects in this reaction type with inability to show tuberculin, mumps, or contact sensitivity skin reactions.¹ On the contrary, if the sensitized T cell present and active is exposed to its specific sensitizer, this cell is encouraged to reproduction and to the production of soluble mediators or lymphokines which in turn effect their particular function.⁴⁴ This cellular activity (or reproduction, and of production of lymphokines) form the basis for laboratory evaluation of function. The lymphokines include the migrating inhibition factor, eosinophilic chemotactic factor, interferon production, cytotoxic factor and others.

Autoimmune Diseases

Some autoimmune and deficiency diseases do not fit neatly into the Gell and Coombs classification and must be considered separately.

Autoimmune disease refers to tissue injury caused by the apparent immunologic reaction of the host to his own tissue. This may be invoked by humoral or cellular mechanisms or a combination of both.

Autoimmune diseases have been described as systemic and as organ specific. Table 2 from Roitt classifies these conditions without regard for where they fall in the Gell and Coombs classification.³³

In a clinical situation, autoimmune mechanisms are sometimes protective. Lymphocytes are important in a surveillance system that is hypothesized to be central to cancer control.⁴⁵ Tumor cells which are constantly being produced in the normal course of events and which are somewhat different from the normal cells are recognized by T cells as for-

eign. In situations where T cells are deficient or hypoactive, tumor incidence is markedly increased.
4.20.46

Deficiency Disorders

The lymphocytic system in the course of development requires a functional bone marrow, viable stem cells which are pluripotential, and an intact and functional thymus. This latter structure derives embryologically from the third and fourth brachial pouch. A developmental deficient brachial pouch, and hence no thymus, results in a clinical condition of T cell deficiency (DiGeorge syndrome).⁴⁷ There is, briefly, an absence of T Cells, a few small lymphocytes in the peripheral blood, inability to reject tissue transplants, and normal immunoglobulin levels reflecting normal B cell function, and because of absent parathyroids there is the life-threatening problem of tetany, especially in the newborn (Fig. 3).

On the other hand, Brutons agammaglobulinemia is a disorder reflecting the absence of B cells with normal functioning T cells still present.

Other diseases reflect deficiency at every possible point along the chain of development. Swiss-type agammaglobulinemia, for instance, first described by Swiss investigators reflects the absence of both B and T cells.

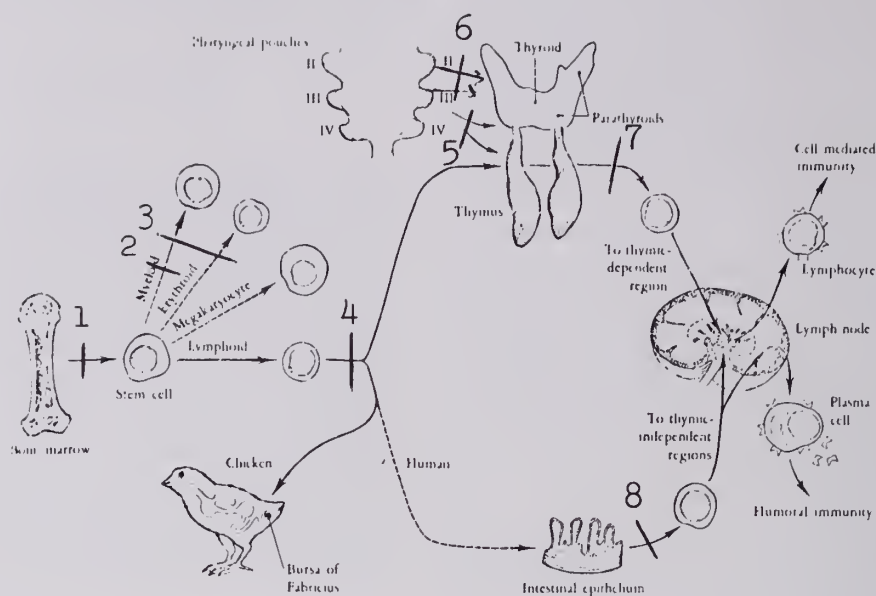
Reticular dysgenesis is a condition with absence of granulocytes, lymphocytes, and immunoglobulins and can only mean the defect is in the development of the stem cell. The accompanying diagram illustrates some of the areas where defects can occur.^{29,48}

A chart listing some of the syndromes associated with deficiency diseases can be found in the Stiehm

Table 2.—Spectrum of Autoimmune Diseases
Organ Specific — Nonorgan Specific

Hashimoto's thyroiditis	Goodpasture's syndrome	Myasthenia gravis	Primary biliary cirrhosis	Systemic lupus erythematosus
Primary myxedema	Pemphigus vulgaris	Autoimmune haemolytic anemia	Active chronic hepatitis (some cases)	(SLE)
Thyrotoxicosis	Pemphigoid			Discoid lupus
				Dermatomyositis
				Scleroderma
Pernicious anemia	Sympathetic ophthalmia	Idiopathic thrombocytopenic purpura	Cryptogenic cirrhosis (some cases)	Rheumatoid arthritis
Autoimmune atrophic gastritis,	Phacogenic uveitis	Idiopathic leucopenia	Ulcerative colitis	
Addison's disease			Sjogren's syndrome	
Premature menopause (few cases)				
Male infertility (few cases)				

(??Multiple sclerosis??)



1. Reticular Dysgenesis
2. CGD
3. Fanconi's Syndrome
4. Thymic Dysplasia (Swiss) (gg)
5. Thymic Aplasia (DiGeorge) (III-IV)
6. Thymic Aplasia (II-III)
7. Thymic Dysplasia (normal gg)
8. Agammaglobulinemia

Figure 3

and Fulginiti text.¹⁵ It will be soon recognized that in addition to primary deficiencies, there may be multiple deficiencies and the variety of clinical states possible are enormous. Basic principles of diagnosis apply to all.⁴⁹⁻⁵¹

I have referred here to genetically determined deficiencies, but it should be remembered that acquired deficiencies can occur, as in nephrotic syndrome, malabsorption, lymphomas, etc.

Laboratory Procedures

Before considering clinical evaluation of the patient, it appears reasonable to consider laboratory procedures, particularly those generally available to most physicians. The competence of each system of defense should be evaluated separately and every possible area of function considered. Tests should be directed at detection of immunoglobulin and/or lymphokines whatever the case may be.

Precipitin Tests

In the first category, there are precipitin tests. This involves the contact of a soluble antigen

with its antibody to make an insoluble and, therefore, visible complex. This can be accomplished at the interface of liquids with the formation of "precipitin rings." Another technique is to allow the two reactants (antigen and antibody) to diffuse toward each other in a gel. There are a number of variations of this technique: single diffusion, double diffusion (Ouchterlony), radial immuno-diffusion, and others.

Immunoglobulin levels can be measured in this fashion. One of the common procedures is the Mancini radial diffusion test.⁵² This is accomplished by putting serum in a small well on agar which is impregnated with an appropriate antiglobulin. Radius of the precipitin band can be measured as a reflection of the amount of globulin in the serum. More recently there has been developed the "Rocket Test" which depends on the same principle but an electrophoretic current is applied and the precipitin band streaks out in a linear fashion. The further the streak goes, the more globulin present.⁵³

Immunoelectrophoresis is a precipitation method in which serum is placed on a gel, one end of the gel plate is given a positive charge and the opposite

end a negative charge. The proteins in the serum migrate at different rates and spread out in linear fashion across the plate. The antiserum, spread out in a trough parallel to these serum proteins, will then diffuse through the gel to give appropriate precipitin bands. Various abnormal serum proteins (the various immunoglobulins, transferin, ceruloplasmin, antitrypsin, lipoprotein, haptoglobin, etc.) can be detected by this technique.⁵⁴

Agglutination Techniques

Particulate antigens when in contact with the appropriate antibody in the presence of the appropriate electrolytes will respond by agglutination. This is exemplified by the common agglutination test for blood grouping and also by the Widal test for typhoid.⁵⁵

Soluble antigens can be attached to various particles and when this complex is exposed to antibody agglutination occurs. This technique is used in such situations as detection of thyroglobulin, gonadotropins, and tuberculin. The particles involved may be latex, bentonite, or red blood cells that have been exposed to tannic acid to make the cell able to absorb antigen (tanned cell hemagglutination technique). The familiar Coombs test is an agglutination technique utilizing anti-human globulin serum to determine the presence of globulin on red cells.⁵⁶

Labeling Procedures

Other procedures use labeled antibodies or antigens. Labeling can be accomplished with fluorescent dyes, peroxidase conjugates, or radioactive materials. A common technique is to apply fluorescein labeled antibody to a preparation containing the appropriate antigen. As an example, biopsy specimens of kidney skin or lung can be exposed to a fluorescein labeled antibody to IgG and will fix on the specimen should IgG be present.⁵⁷

Indirect immunofluorescence is useful when antigen has been exposed to unlabeled specific immunoglobulin antibody. The resultant antigen-antibody complex is then treated with fluorescein labeled antibody directed at the unlabeled immunoglobulin moiety. The now labeled complex can be visualized.

These techniques are useful in disorders such as lupus erythematosus, a variety of immune diseases, renal disorders such as Goodpasture's syndrome, syphilis, toxoplasmosis, etc. The antinuclear antibody test (ANA) is such a fluorescent technique.⁵⁸

Immunoperoxidase procedures depend on the histochemical reaction between peroxidase and its substrate to give a visible product. It has the advantage of being visible under an ordinary light microscope.⁵⁹

Radioimmunoassays are another labeling technique, and there are a variety of tests depending on combinations of precipitin, agglutination and immunofluorescent techniques.

Cell Functional Tests

Cell mediated immunologic reactions can be evaluated in vitro and in vivo. The two tests that enjoy the greatest popularity at this time are migration inhibition and lymphocyte transformation. The first depends upon the knowledge that macrophages (easily available from peritoneal exudate of guinea pigs) tend to migrate out of capillary tubes in which they are placed. If a patient's lymphocytes are exposed to specific antigen, MIF is produced, and if this material is now added to the medium used for the incubation of the macrophage containing tubes, then the migration does not occur in the presence of antigen.¹⁰ This is utilized as a measure of delayed (type IV) sensitivity.

Lymphocyte transformation is another measure of cell mediated disorders, but it is not as specific as the MIF test. Transformation may involve antibody synthesizing cells (B cells) as well.⁶⁰ The mechanisms for recognition of lymphocyte transformation in various laboratories may differ, but all take advantage of the tendency of the cell to reproduce on exposure to specific antigen. Thymidine is a chemical necessary for the reproduction of cells. If, as in this case, the thymidine is made radioactive, and the cell exposed to specific antigen, the amount of thymidine taken up can be measured. The degree of blastogenesis (Blast transformation) can thereby be measured. This is then compared to a control sample. This test is useful in diagnosis of certain immunodeficiency diseases, evaluation of drugs sensitivity and other situations where immunologic activity is in question. Testing can be done with specific antigens (as PPD, monilia, mumps vaccine which affect T and B cells) or nonspecific mitogens such as pokeweed (affecting B cells for the most part) concanavalin A, or phytohemagglutinins (PHA) (affecting T cells for the most part). This is only a general response, however, and both populations (T and B) do respond in part to all these mitogens. Chess et al note, however, that only T cell populations proliferate in response to specific soluble or cell surface antigens.⁶¹ Conditions such

as Hodgkin's disease,⁶² sarcoid,⁶³ Sjogrens syndrome, etc., may show abnormal transformation tests.

Another test is the rosette which depends upon the propensity of sheep erythrocyte to agglutinate on T cells to form what appears to be a rosette on microscopic examination.⁷

The in vivo procedures include only skin test responses which are another test of lymphocytic functional integrity. Tests for tuberculosis, histoplasma, mumps, killed vaccine, tetanus, streptokinase-streptodornase (SK-SD), trichophyton, and monilia are all pertinent. A battery of skin tests will give a good index of the delayed T cell function. The materials most commonly used are SK-SD, monilia, or mumps. Tetanus toxoid is a good antigen. With these tests, better than 95% of people will show at least one positive reaction. Several of the tests are necessary because previous exposure to any single antigen is not certain. If the patient should be negative to these tests, one can sensitize and test the patient to DNCB (dinitrochlorobenzene). DNCB not only tests the ability of already sensitized T cells to respond, but also the ability of uncommitted T cells to be sensitized. In this test, the skin is sensitized by a solution of DNCB (2000 ug/.1 cc), is covered for one to two days, then four weeks later it is challenged with a dilute solution of DNCB (50 ug/.1 cc). Adequate controls should be incorporated into the procedure and care should be exercised not to sensitize laboratory personnel.⁶⁴

Finally, there is a miscellaneous group of manipulations designed to demonstrate antigen-antibody activity. Passive cutaneous anaphylaxis (PCA) is one such technique. Here an antiserum or antibody is injected into the skin of a test animal. The antigen, along with a dye such as Evans blue, is injected intravenously. At the site of antigen-antibody union, there will be a concentration of dye as a result of the diapedesis occasioned by histamine and other allergic mediators. This test is referred to in the literature. It is not a clinical tool but an experimental one. Of particular interest is the radioimmunoassay technique such as the RAST (radioallergoabsorbent test). In this test an allergen such as ragweed is bound to insoluble particles. Specific IgE antibody to the allergen as might be found in a test serum is then directed to it. The IgE antibody, if present, will then attach to the corresponding allergen. A radioactive anti-IgE preparation is added, and one can then measure the amount of IgE by determining the radioactivity that is residual after washing. From a clinical point of view this test

is of limited value because of the relatively few antigens available and indeed the literature notes that a properly done skin test yields the same information.

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Part II of this article will be published in the October issue of the Journal.

► Dr. Hammond, 350 Northeast 15th Street, Miami 33132.

New, Updated CHAMPUS Allowances Effective July 1, 1977

New, updated CHAMPUS allowances based on 1976 charges for medical services went into effect July 1, 1977. The Office of Civilian Health and Medical Program for the Uniformed Services (OCHAMPUS) has instructed all contractors nationwide to implement the new allowances for all claims received on or after July 1, 1977.

Two different types of CHAMPUS allowance profiles are determined: (1) the **Individual Physician Allowance Profile**; (2) the **Area Allowance Profile**. The 50th percentile of the **Individual Allowance Profile** is compared to the 75th percentile of the **Area Allowance Profile** for a given medical service. The CHAMPUS allowance is then the lower of the two.

Malpractice Suits Are Not The Only Legal Risk

C. Brooks Henderson, M.D.

In the fall of 1976 I discovered that not all authorities accept the proposition that the decision as to admission or nonadmission to a hospital is to be made by a physician. If that is so it will be of increasing importance to all of us as we deal with ever-increasing governmental intervention in hospital care. Like most physicians I had always assumed this was a prerogative solely our own.

Prior to 1972 involuntary admission to psychiatric hospitals in Florida was carried out under law and procedures which were admittedly archaic and offered little protection to the prospective patient other than the presumed integrity of his doctors and the courts. Allegedly there were serious abuses under those procedures. The most famous, I suppose, was that of Kenneth Donaldson whose recovery of damages from two dedicated staff members of the Florida State Hospital was sustained in a recent landmark decision of the Supreme Court of Florida. Even that case was judged by the standards of a different day than that in which the alleged abuse occurred. Nevertheless Representative Maxine Baker and the Florida Mental Health Association were sufficiently impressed that they felt the need for a new mental health law with more safeguards for patients' rights. Many practicing psychiatrists in the state had also felt the need for updating the law but had never been able to achieve any significant change. It is my understanding that Florida psychiatrists offered their assistance in writing the proposed law but were actively refused by those responsible for its final form. The instrument that was eventually produced and passed into Florida law under the name of "The Baker Act" is a cumbersome device so overloaded with protections for the patients' rights that it could become almost impossible to

hospitalize a patient involuntarily no matter how psychotic, if he were skillfully represented by an attorney who did not believe that hospitalization was in his client's best interest. This Act is so complicated that its administration calls for 50-odd forms and a whole volume of instructions. The instructions are repeatedly and extensively modified but have never been significantly simplified. No major change has been made in the law itself since its passage.

A great many of us had proven for years before that good psychiatrists could provide good treatment in spite of a bad law. We continued to do so even though the amount of paperwork and complexity was greatly increased by the Baker Act.

(By way of clarification for what follows, initial hospitalization under the Baker Act is carried out in designated hospitals which are referred to as "receiving facilities." Each receiving facility serves a designated area known as a "catchment area.")

In September of 1976, while I was on call as admitting psychiatrist for the local receiving facility, a judge who was not at the time sitting in our catchment area, ordered a patient, who did not reside in the catchment area, into our receiving facility. The patient arrived without notice and with paper work indicating that the patient was likely to require care in a locked security room. No such space was available and I refused the admission in the interests of the safety of the patients already on the unit and the patient whose admission had been ordered. Appropriate space was available in the receiving facility of the catchment area where the patient resided and where the judge was sitting.

I subsequently received a telephone call from the judge in which I thought I had satisfied him that the reasons for my decision were compelling. The

following morning I, along with a number of other individuals who were administratively involved, received a summons to explain why I should not be held in contempt of court (potential penalty \$5,000 fine and/or six months in Jail!) I immediately contacted the local Mental Health Center, who contracts with the local hospital to serve as the receiving facility, and the hospital. In both instances I was advised that I had best obtain my own legal representation as my interests in the case might not be the same as theirs. This distressed me — I had been acting to protect their patients and to protect them as well as myself from a potential malpractice suit — but of course I did obtain a lawyer.

As the case unfolded it developed that the Baker Act is ambiguous in a number of areas: (1) The order for emergency admission specifies that the patient shall be delivered to the "nearest receiving facility." This is not always the one for the designated catchment area. Which one is meant? (2) What is the authority of a judge to order a patient into a designated receiving facility other than the one for the patient's catchment area? (3) What exactly is an "emergency admission"? Does this mean an admission in the usual sense of a hospital admission? Or will an immediate evaluation after which the patient might be sent on their way serve the purpose? (4) And potentially of greatest significance to physicians: Can a physician be ordered to admit a patient under circumstances

which he feels are not in the best interests of the health and safety of the patient and/or other patients? Or to put it another way, can a physician be ordered to accept a patient when he does not have appropriate facilities to safely treat the patient — and when such facilities exist elsewhere?

After seemingly endless legal proceedings the case came to trial and I received a directed verdict of acquittal. In other words, the trial judge decided that the prosecution had not made a case against me. I was happy to be "off the hook" without further proceedings but unfortunately this decision left the above mentioned questions unanswered. Unless the matter can be remedied by a change in the law it will eventually have to be decided by some other physician going through essentially the same procedure and on through the appellate courts until a binding precedent can be set. With increasing governmental involvement in medical care this same type of question will ultimately involve non-psychiatric physicians and their patients.

The experience, by the way, was a very expensive one, somewhat alleviated by assistance from the legal defense fund of the FMA and by my County Medical Society. The pleasant part of the experience was the large number of people who expressed friendly interest and willingness to provide tangible help.

● Dr. Henderson, 2 Southwest Twelfth Street, Ocala 32670.

**Internuncial neurons disdain to transmit their
impulses . . .**

**and the long smooth muscle tube becomes a soggy
limp bag.**

The tube tip never gets the message to open . . .

**Inert like a stuffed sausage lying in the hollow of the
chest,**

**Food trickles through providing scant nourishment
for a slowly starving body.**

ACHALASIA OF THE ESOPHAGUS

F. N. V.

Rural Health Initiative

James A. Hinson III, M.P.H. and E. Charlton Prather, M.D.

The problem of inadequate health services in medically underserved areas presents a unique opportunity for the implementation of innovative delivery systems which provide access to a full range of health services, including secondary and tertiary care, available 24 hours per day, seven days per week.

The United States Public Health Service (USPHS), in order to meet the unique needs for rural health care, has developed and is implementing a program known as "Rural Health Initiative." The purpose of this new program is to encourage, stimulate and assist in the development of new approaches for service delivery in rural underserved areas and the promotion of coordinated linkages where there are resources and services currently available.

Rural Health Initiative (RHI) grant funds are not limited to freestanding entities. Private practitioners may also participate in the new program by expanding their present practices into medically underserved areas through the RHI program by:

A. Use of Physician Extenders — Appropriate use of Nurse Practitioners and Physician's Assistants is one innovation encouraged by the RHI program;

B. Contractual Physician Coverage — One or more practitioners or groups of practitioners might provide physician coverage and services through a contractual agreement with an RHI grantee;

C. Recruitment of Health Professionals — Health professionals in those areas that are adequately served and are adjacent to underserved areas might move into the underserved areas or might establish a satellite health center in the underserved area and recruit new personnel under the auspices of an established group practice;

D. Consultant Referral — Group practices are frequently able to provide essential, high quality support services through contractual arrangements with an RHI grantee in order to address fully the health problems of rural areas;

E. Linkages — If any group or agency, e.g., county health units, other federally funded programs, medical school training programs including residencies, existing practitioners and group practices, area health education centers, or other such entities, has unused capacity which could be redirected to underserved areas, it is expected that this capacity will be used, instead of recruiting and placing additional resources. The RHI program will provide funding support only for what is actually required to develop and implement health services in the underserved areas;

F. Assistance In Planning — Some communities or larger geographical areas may need assistance in developing an appropriate applicant entity.

The RHI program is designed to provide funding support for complete health services, both medical and dental, such that any deficiencies may be eliminated from the health care delivery system of the underserved areas. The Federal grant funds, managed by local staff, may be used along with available local funds or contributions and project earned revenue and fees to provide personnel, equipment, transportation, contractual services and renovation of existing physical facilities.

Total Federal grant support will not exceed three years; thus, project financial planning showing continuance in the community and self-sufficiency must also reflect a decreasing dependency on Federal funds. First year grant awards are usually in amounts between \$50,000 and \$200,000.

Planning grants of up to \$25,000 are available. Covering a maximum six-month period, these grants should result in a completed RHI project plan and application for project funding support.

Applicants for RHI funds may be any public or private nonprofit entity within a medically underserved rural area and which has its principal headquarters and service delivery site within the proposed service area. The service area should be within one HSA.

Any individual or agency desiring additional information may write or call the following offices.

Florida Department of Health & Rehabilitative Services
Health Program Office
Rural Health Program
1323 Winewood Boulevard
Tallahassee, Florida 32301
Telephone: (904) 487-2997

Department of Health, Education and Welfare
Region IV
Division of Health Services
50 - 7th Street, N.E.
Atlanta, Georgia 30323
Telephone: (404) 881-4904

The development and implementation of the RHI program, together with the available Federal funding assistance and support, provides a singularly unique opportunity for the medical

Mr. Hinson is Supervisor, Rural Health Program, Health Program Office, Department of Health and Rehabilitative Services, Tallahassee and Dr. Prather is Staff Director, Health Program Office, Department of Health and Rehabilitative Services, Tallahassee and Associate Editor of The Journal.

community of Florida to address the health service needs of the medically underserved areas of the state. This program can foster the development of linkages and relationships between the public and private sectors of the medical care delivery system such that a broad-based, comprehensive range of health services may be made available to the vast rural areas of the state which experience a severe lack of medical manpower and service.

- Mr. Hinson, Health Program Office, Department of Health and Rehabilitative Services, Tallahassee.

Vice President For Health Affairs Dean, College of Medicine

University of Florida
J. Hillis Miller Health Center
Gainesville, Florida

The University of Florida invites applications for the position of Vice President for Health Affairs and Dean of the College of Medicine.

The Vice President administers the affairs of the J. Hillis Miller Health Center at the University, which has the function of advancing human health and educating tomorrow's leaders in the health professions.

The Center includes the College of Dentistry, College of Health Related Professions, College of Medicine, College of Nursing, College of Pharmacy, and the new College of Veterinary Medicine. The Shands Teaching Hospital and Clinics, a 450-bed referral hospital for critical patient care and clinical training, is located within the Health Center.

The Vice President reports directly to the President of the University and provides general policy supervision and guidance to the Deans of the colleges associated with the Health Center, to the Director of the hospital, and to the Director of Student Health Services. The appointee also holds the position of Dean of the College of Medicine. Financial responsibility includes administration of an \$85,000,000 budget.

Candidates for the position must hold the Doctor of Medicine degree and have a minimum of ten years' experience in university level research, service, and administration in the health care field. Screening and selection for this position are conducted in the open.

Nominations or resumes should be directed to H. P. Hanson, Executive Vice President, University of Florida, Gainesville, Florida 32611.

Application deadline is November 1, 1977.

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MEDICAL MESSAGE
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No one likes medical bills!
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MEDICAL MESSAGE
from the Florida Doctors

Scoliosis Screening
any previously-dreaded childhood disease... day are prevent... s. One espe... which... In... diagnosed early, scoliosis can be successfully treated using... ce. In... zery

Dade County Medical Society
one family of four spent its after-tax care in 1970, scarcely

Polk County Medical Association
A promising pilot program of screening for scoliosis in Central Florida succeeded in examining 40,000 children in grades seven through nine. Of those, slightly less than two per cent were referred to private physicians or public health departments with recommendation for x-ray evaluation of the spine.



SPECIAL ARTICLES

Introduction

Many persons know of someone with a near-death experience as here described by Doctors Kreutziger and Sabom. Accounts are appearing with increasing frequency in the lay and religious press.

"On Death and Dying" (Dr. Kübler-Ross) focused particular attention to the subject. Dr. Raymond A. Moody's "Life After Life" adds challenging credence to the observations of others.

Understanding of the phenomenon is speculative. Few critical analyses have been attempted. Doctors Kreutziger and Sabom's "Near Death Experiences" is presented and in the words of the authors, "in the hope that an increased awareness and acceptance of these phenomena will better enable the medical profession to deal with patients who have encountered these unique experiences and that a greater insight into the significance of these findings will follow."

E. Charlton Prather, M.D.
Associate Editor

Near-Death Experiences

M. B. Sabom, M.D., and S. Kreutziger, M.S.W.

ABSTRACT: Remarkable and unique phenomena occurring in people encountering near-death situations have recently stimulated considerable public interest. Little documentation of these experiences is present in the general medical literature and few physicians are aware of their occurrence. Eleven near-death experiences are reported and were found to be consistent with those published elsewhere. Even though a clear explanation of these phenomena is presently not available, it is hoped that greater physician awareness and reporting of similar experiences in their own patients will both benefit the patient involved and lead to a greater insight into this poorly understood topic.

Considerable public interest has recently been stimulated by several reports^{1,4} in the lay literature of unique phenomena experienced by individuals during near-death encounters. The best known of these published accounts is Raymond A. Moody Jr.'s book, "*Life After Life*,"⁵ which recently reached the best seller list and was reviewed in the January 1977 edition of *Reader's Digest*. Even though the majority of these experiences occurred in patients while under medical care, little documentation of these near-death phenomena can be found in the general medical literature. In addition, an informal survey of medical center physicians failed to uncover an awareness of the existence of these phenomena in severely ill patients. We undertook the following investigation in an attempt to substantiate the occurrence of these phenomena in patients of our own and to evaluate their consistency with the reported findings of others.

From the Departments of Medicine and Psychiatry, University of Florida College of Medicine, Gainesville.

Patients and Results

Approximately 50 patients who had suffered a documented near-fatal crisis resulting in unconsciousness were interviewed. Cardiac arrest with successful resuscitation was the most frequent near-death occurrence. Most patients remembered nothing during their period of unconsciousness. Eleven patients, however, had definite recollections, while unconscious, of either viewing their body from a detached position of height several feet above the ground (autoscopy) or of "traveling" into another region or dimension (transcendence) (Table 1). Each of these 11 patients was initially reluctant to discuss his experience for fear of ridicule, each requested to remain anonymous if further use of the taped interview was to be made, and none had read or heard of similar accounts from other sources prior to the interview. No apparent factor including age, sex, religious affiliation, education, social background, or psychiatric history could identify which patient would be more likely to experience these phenomena if the conditions were appropriate.

Of the four patients who experienced autoscopy, all described "floating" up above their bodies while physically unconscious and viewing the efforts of others to revive them. A calm, detached feeling was present while they observed

events in clear detail "as if sitting in a balcony watching a movie." When these visual recollections were compared to the actual events documented by others present, the accuracy of the autoscopic visualizations was substantiated. A typical autoscopic experience was recalled by Patient 3 (Table 1):

"I knew something was going to happen . . . and then I went unconscious . . . and I was looking down and could see myself going into convulsions and I was starting to fall out of bed. And the girl in the next bed screaming for the nurses . . . The nurse caught me and put me back and by then there were two other nurses there and one came back almost immediately with a tongue depressor on my tongue. And they got the sides up on the bed and they called the doctor . . . It was a feeling of height, great distance, a light feeling, like being up in a balcony looking down and watching all this and feeling very detached as though I was watching someone else, like you might watch a movie . . . It was a very calm, relaxed feeling, a feeling of well-being if anything . . . everything was clearly seen like watching television . . . It looked very ugly to me to see my body thrashing around on the bed . . . and the way I was jerking around on the bed . . . it was very frightening to the girl in the other bed . . . The convulsion didn't last very long and the next thing I was aware of, I don't know how the change takes place, but I woke up the next morning and I was back to me again."

Eight of the 11 patients experienced a "transcendence" episode during which they felt as if their consciousness passed into a new and unique dimension allowing them to experience a "unity with the universe." Most entered a beautiful, serene

TABLE 1. — CLINICAL DATA

Patient	Age	Sex	Occupation	Crisis Event	Type of Experience
1	28	F	College Student	Drug Overdose	Autoscopy ¹
2	38	M	Farmer	Stokes-Adams Attack with Complete Heart Block	Autoscopy
3	38	F	Housewife	Toxemia of Pregnancy with Grand Mal Seizure	Autoscopy
4	33	M	Unemployed	Cardiac Arrest - Auto Accident	Transcendence ²
5	50	M	Businessman	Cardiac Arrest - Myocardial Infarction	Transcendence
6	76	F	Retired School Teacher	Cardiac Arrest - Myocardial Infarction	Transcendence
7	39	F	Housewife	Cardiac Arrest - Posthysterectomy	Autoscopy and Transcendence
8	32	F	Housewife	Coma - Hepatic and Renal Failure	Transcendence
9	23	F	College Student	Cardiac Arrest - Postnephrectomy	Transcendence
10	60	F	Social Worker	Cardiac Arrest - Open Heart Surgery	Transcendence
11	51	M	Retired Businessman	Cardiac Arrest - Myocardial Infarction	Transcendence

¹Autoscopy denotes self-visualization from a detached position of height.

²Transcendence denotes passage of the consciousness into a foreign region or dimension.

and brightly lit environment which was occupied by the presence of other people often identified as deceased relatives or friends. A nonverbal interchange of thoughts sometimes occurred with one of these presences. Although a basic structure of each of these experiences was very similar, the details of the encounter were often given individual interpretation. The following episode of autoscapy and transcendence was experienced by Patient 7 (Table 1).

"I knew I was dying because the pain was so bad . . . it was like a bullet hitting my heart. The pain was so bad you just couldn't stand it . . . I called the nurse and by then she couldn't find no respiration or nothing . . . And you could see yourself just floating up in the air and you could see your own body and them working on it while you're just floating. And you see people who have been dead for years and you talk to them . . . I love them, like my mother and daddy. And they were both dead. In fact she had her own baby that was still-born in her arms . . . it was like a borderline. There was a gate-like and it was real beautiful . . . the sun was so bright and shiny. It was like another world . . . it's white with clouds and grass and beautiful trees . . . like this but a beautiful sunny day, but everything is so bright and clean. And everyone is so happy . . . I didn't know what to do. I was trying to get there, but something kept pushing me back and then the good Lord popped up and he said, 'Go back, go back. Your kids and a lot of people are going to need you. We don't need you now.' And I then got to drifting back and I was still floating in between . . . and I could hear Dr. _____ talking to me and all."

Discussion

The existence of these phenomena has been known for quite some time. In 1892 Professor Albert Heim⁸ published results of extensive interviews with survivors of mountain climbing or similar near-fatal accidents. Heim found that at the time of greatest physical distress, most of these individuals experienced a transcendence episode similar to that reported by our patients. More recently other investigators have substantiated Heim's findings. Noyes and Kletti⁷ reported over 100 cases of near-death experiences in addition to the 150 found in Moody's book.⁵ These authors both found remarkably similar descriptions of autoscapy and transcendence experiences in their patients who consistently described the great calm and peace which pervaded the episode, the sense of detachment from the physical body and the "mystical extension of the consciousness" which resulted in a feeling of "oneness with the universe." In addition, Moody gave several detailed accounts of vivid autoscopic experiences which were often authenticated, as in our patients, by other witnesses.

A partial analysis of these phenomena was attempted by Noyes and Kletti⁸ who felt that a type

of depersonalization in the face of life-threatening danger may be a basic adaptive mechanism of the nervous system. The great calm experienced in this situation may allow the individual to react in the most advantageous manner to afford self-rescue from the threatening source. When no chance of survival is present, the calm and peaceful feeling may then protect the consciousness from the painful reality of death. In addition, the sense of detachment and "split of the self-representation into participating and observing aspects" could represent the ultimate defense against the anxiety of dying. However, Noyes and Kletti were unable to adequately explain many aspects of these phenomena and concluded that "A single or unified interpretation of the subjective experiences during moments of life-threatening danger is not available to us."

Although the meaning of these near-death phenomena is unclear, the following conclusions can nevertheless be reached from this survey: (1) Unique and detailed phenomena are frequently experienced by individuals faced with acute life-threatening situations; (2) the structure of these phenomena exhibits a high degree of inter-patient consistency; (3) physicians are generally unaware of these occurrences in their own patients who are reluctant to retell the experience for fear of ridicule; and (4) the patient who has experienced these near-death phenomena is often relieved at being able to discuss his experience in an atmosphere of openness and understanding and is comforted with the knowledge that others have had similar encounters.

It is hoped that an increased awareness and acceptance of these phenomena will better enable the medical profession to deal with patients who have encountered these unique experiences and that a greater insight into the significance of these findings will follow.

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- Dr. Sabom, Department of Medicine, Division of Cardiology, Shands Teaching Hospital, Gainesville 32601.

The Health of the People

Malcom Randall

"The health of the people is really the foundation upon which all their happiness and all their powers as a State depend."

Disraeli, 1877

Editor's Note: At periodic intervals, the Editors of the Journal publish articles and commentaries that have elicited a wide spectrum of opinion from the reviewers. Such is Mr. Malcom Randall's article entitled "Health of the People."

Mr. Randall is one of the most talented and respected hospital directors in the Veterans Administration Hospital System; and he has played the key role in affiliating the programs of the V.A. Hospital in Gainesville with those of the J. Hillis Miller Health Center at the University of Florida in order to provide a superior patient care system in an educational environment.

He has consistently been a loyal and effective friend of organized medicine. Indeed, in his role in the State Health Coordinating Council, or as a member of the board of North Central Florida's Health Systems Agency, he has frequently enunciated the key role of the physician.

Abstract: Although this country has produced a quality of care which is unequalled, there is a rising tide of criticism about health care. Much of this criticism is generated by costs and a perceived lack of sensitivity on the part of health care professionals in dealing with patients. Although the validity of the charges on which this criticism is based can be questioned, health care professionals must assume responsible roles in improving our delivery system, in containing costs, and in assuring that care is delivered in a concerned, compassionate manner. Since a considerable amount of the care in this country is centered around hospitals, we must insure that our hospitals have "lives of their own," and can function as responsive, holistic, social institutions. To do less is to invite further regimentation and control.

The rising voices of dissatisfaction over the issue of health care should give us pause. The people of this country appear to be disenchanted with health care in three areas: costs, access, and quality. Overlaying these, there seems to be a persistent feeling that those of us who deliver care provide it in a cold impersonal manner insensitive to the patients' psychosocial needs.

There is some evidence that this perceived lack of sensitivity on our part has alienated many of those who are seeking service from those who are providing service. I do not pretend to be an oracle, but I do believe that the people are no longer willing to accept health care delivered on our terms and under conditions which we prescribe. I believe they are going to demand that care be delivered in a concerned, courteous, compassionate, considerate manner. If our health care delivery system is going to survive as we know it, I am convinced that we must cause the people of this country to feel that as health care professionals, we care about them as human beings.

The Veterans Administration Hospital receives a large number of letters praising the care patients receive. This is significant for people rarely write when they are pleased about something. Rather they write when outraged at the treatment and feel compelled to respond.

The most significant point about the letters, however, is the similarity of content. Patients and families are not really qualified to judge the quality of care they receive, nor competent to assess whether the surgeon did a good job, the anesthesiologist provided superb service, or the nursing staff did an outstanding job in postsurgical recovery. Yet, patients and families mention "brilliant physicians," "outstanding nursing care," "superb medical care," and "outstanding hospital care." They are talking about how they and their families were treated as human beings, and this they translate into judgments about the quality of their care.

Mr. Randall is Director of the Veterans Administration Hospital in Gainesville, and Professor of Health and Hospital Administration at the University of Florida.

This article is a condensation of the address prepared for delivery at a meeting of the University of Florida Health Center - Veterans Administration Dean's Committee in December 1976.

No matter how brilliant and scientifically superb the care provided, unless patients and families feel that we care about them as unique, pricelessly different human beings, they will perceive that they have received "bad care." Therefore, each one of us involved in delivery of care must make a conscious effort to insure that it is delivered in such a manner to make the patient and his family feel we care about them. Each of us must contribute to establishing a milieu that says to every person who enters the hospital, "This is a caring institution."

Health professionals need to be concerned about accessibility of care. Hand in hand is the issue of timeliness. There are far too many people who face barriers to accessibility for either economic, social or geographic reasons. If these barriers are removed, the problem of timeliness remains. Care provided in less than timely fashion can be detrimental to the medical needs of the patient, in addition to his psychological needs. But this issue is much too complex for me to deal with here in any meaningful fashion.

Next is the problem of cost. The rapid spread of regulatory measures such as utilization review, restrictive reimbursement formulas for third party payments, certificate of need laws, PSRO's and the new health planning law were generated by the persistent rise in costs. Present estimates indicate that national health expenditures reached \$118.4 billion in fiscal year 1975, an increase of almost 14% over the previous year. From 1955 to 1975 expenditures increased 584%. Utilization, including increasingly more complex care and treatment, has contributed to the rise but prices have been the largest factor. After some containment during the economic stabilization program ending in April 1974, they began rising again. For example, from April 1974 to August 1975, medical care services rose on an annual basis at a rate of 49% more than all other services. In the last month of this period (July-August 1975) medical services advanced at an annual rate of 73% more than other services with hospital charges playing the largest part in the increase.

There are factors contributing to these increases in cost over which we have no control, but there are significant portions over which we do have some control. We have not been concerned enough about costs and have brushed off questions with the response that the questioners are uninformed or simply do not have the background to understand. We have been defensive when we should have critically attempted to contain our costs. We have

drawn a "gauze curtain" around our operations that would make the "iron curtain" seem porous. In too many instances we have retreated behind this "gauze curtain" oblivious to the fact that this tactic does not address the problem nor satisfy our critics. The time may well have come when decisions need to be made regarding what proportion of the gross national product the country can afford to devote to health care. Some believe that if rising costs go unchecked, they will outstrip the ability of this country to fund them.

From a parochial point of view, what implication does all this have for those concerned about the future of the Veterans Administration Hospital, Gainesville? It has finite resources. These cannot possibly meet the demands placed upon them by each of us individually no matter how exemplary the purpose nor worthy the intent. There is not enough money to do everything each of us feels should be done, to the degree that each is certain it is required; nor can we provide the level of services each of us conscientiously wants to provide to all the patients we feel should be served. We cannot be all things to all men.

Each of us must recognize that we can do only that which our resources will permit and, at the same time, never relinquish our constant search for excellence. Excellence cannot be equated to dollars alone. I am sure you will agree that the pouring in of additional dollars to a health care institution will not guarantee excellence. The state of excellence is much too fragile and much too complex to be purchased with mere dollar outlays. But I am convinced that excellence can be approached, and perhaps achieved, if each of us will make a commitment to using the resources that we do have as wisely and effectively as possible. This might require making a decision that although a particular service might be improved by the infusion of additional funds, will it be improved sufficiently to justify the expenditure?

A hospital is a complex, interdependent social organization with each function inexorably bound up with every other function. If we permit one necessary program or service to wither because we have drawn off resources for other programs or services, then all programs inevitably deteriorate. None are served well if we permit the hospital's ability to respond to patient care needs to deteriorate, least of all the patients whose lives are entrusted to our care.

I am acutely aware that the finest medical care most often can be provided in a setting based on the triad of clinical care, education and research. I have

a commitment to education and research as well as clinical care, but I am convinced that sound clinical education cannot exist unless based upon good patient care. I am equally concerned that research cannot flourish unless it exists in a climate of good patient care and sound education. All three should operate in an environment where they are mutually supportive, where one element is not crippled in the process of enhancing the other two.

In an organization as complex as a hospital with many and varied forces constantly at play, we must be continuously alert to subtle signs which indicate that the integrity of the hospital as an institution is being eroded. A hospital must have a life of its own. If it does not, its ability to meet the needs of patients, the professionals who deliver health care, and society at large is compromised. Society is demanding that hospitals be responsive as social institutions. In order to do this they must have

cohesive, logical organization, equipped with policies, systems, and procedures which permit them to be responsive to their own needs and to the patients they serve.

In the face of the rising tide of criticism about health care, those of us who are health professionals must assume responsible roles in insuring that the health care system in this country, which as produced an unequalled quality of care, remains a viable system. If we fail, the people are going to demand controls that will be painful to all of us, and generate legislative regimentation that could stifle and cripple our ability to deliver quality care. We have a vital stake in the direction health care takes in the future. The time is now; we cannot wait until tomorrow.

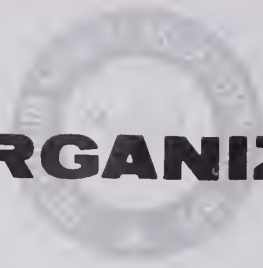
- Mr. Randall, Director, Veterans Administration Hospital, Gainesville 32610.

MULTIPHASIC CENTER LICENSING LAW

The Florida Department of Health and Rehabilitative Services is seeking the cooperation of physicians in identifying certain multiphasic testing centers that must be licensed under a new law.

Facilities that take specimens from the human body for analysis by registered clinical laboratories and perform other health tests and measurements must be licensed by January 1, 1978. State officials said there may be as many as several hundred such centers.

HRS Secretary William J. Page, Jr., said physicians may report centers for licensure by calling (904) 354-3961, Ext. 416, or by writing to P. O. Box 210, Jacksonville 32201.



ORGANIZATION

FMA Public Relations Institute In Tampa, September 16-18

A three-part Public Relations Institute will be conducted by the Florida Medical Association at the Airport Holiday Inn in Tampa, September 16-18. Seminars on negotiations, public speaking and public relations will be included.

The program will begin Friday afternoon, September 16, with an American Medical Association Negotiations Seminar. J. Paige Clousson, J.D., Director of the AMA Department of Negotiations, will be moderator.

The Negotiations Seminar will continue on Saturday morning, September 17, and Sunday morning, September 18.

On Saturday morning, an FMA Speakers Seminar will begin with Robert A. Lang, Ph.D., of the Cleveland Academy of Medicine, and Edward R. Annis, M.D., of Miami, as moderators. That program will continue Sunday morning.

Saturday will be devoted to the FMA Public Relations Seminar, with an optional workshop

scheduled at 9:30 a.m. The formal seminar will commence at 1:00 p.m. FMA President Louis C. Murray, M.D., of Orlando, will welcome participants.

Speakers and their topics include:

"The National Scene" — James H. Sammons, M.D., Executive Vice President, American Medical Association.

"Our Public Relations Inventory" — Vernon B. Astler, M.D., Boynton Beach, FMA Public Relations Officer.

"A Speakers Bureau Works for You" — Edward R. Annis, M.D., Miami, Chairman of the FMA Speakers Bureau.

"Sarasota County: A Positive Picture" — Robert E. Windom, M.D., Sarasota, FMA Secretary.

The Public Relations Seminar will end late Saturday afternoon. The Negotiations and Speakers Seminars, for which registration is limited to 30 and 25 participants, respectively, will adjourn about noon on Sunday.

Chest Physicians Are First With 1978 Program

Chest physicians are the first to complete arrangements for their 1978 scientific program at the Annual Meeting of the Florida Medical Association.

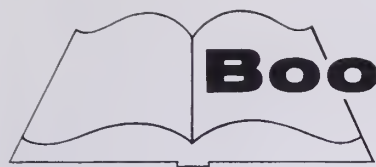
A. Jay Block, M.D., Program Chairman for the Florida Thoracic Society, said next year's Section on Chest Medicine would consist of "Selected Topics in Noncardiogenic Pulmonary Edema."

The session will be held from 2:00 to 5:00 p.m., on Thursday, May 4, 1978, at the Diplomat Hotel in

Hollywood under the co-sponsorship of the Thoracic Society, the Florida Chapter of the American College of Chest Physicians, and the FMA.

The FMA Committee on Continuing Medical Education will strive again this year to have the scientific program complete by October 1.

Henry M. Yonge, M.D., of Pensacola, is Vice Chairman of the Committee on Continuing Medical Education and Annual Meeting Scientific Program Chairman for 1978.



Book Reviews

Book Review Editor

F. Norman Vickers, M.D.

The Trouble With Rape by Carolyn J. Hursch, Ph.D. Price \$8.95. 194 Pages. Nelson-Hall Publishers, Chicago, Ill., 1977.

From 1968 to 1973, the FBI reports, the number of forcible rapes rose 62% nationally. This increase closely parallels the development of the women's movement. Is there a relationship? Dr. Carolyn Hursch in her book "The Trouble with Rape" says that there is. Young women are now being taught that they are equal to men. Intellectually, this is certainly true, but a 110 pound woman is no physical equal of a 170 pound man. Imbued with the spirit of their independence, some women are hitchhiking alone, walking alone at night, living alone in apartments which are easily accessible from the street. Many are being raped.

This excellent book will help thousands of rape victims to recover from this humiliating, debasing, life-endangering trauma and perhaps many more potential victims could avoid it. Based on data collected from 1,108 victims studied at the Violence Research Unit of Denver General Hospital, "The Trouble with Rape" provides factual answers to many questions. Who gets raped? Nice girls and women, aged 3 to 86 years, **anyone** whom the rapist can capture while she's alone in a place where he is not likely to be apprehended. Why doesn't the victim relax and enjoy herself? Rape is a violent, degrading crime in which the victim is often assaulted, insulted, and made to perform humiliating acts by a stronger, bigger man (or men). Would a 110 pound boy or man relax while being brutally beaten by men (or women) nearly twice his weight with a knife held to his throat? Would he enjoy himself while a dirty coke bottle picked up off the street is repeatedly rammed into his pelvis?

Written in a clear, crisp, easy to follow style, "The Trouble with Rape" provides facts and dispels fictions about this highly emotional subject. It is the most rational and pragmatic analysis of this topic that I have seen. This book should be read in college programs of social sciences of health education and

in high school health classes. Family physicians should study it in order to counsel their female patients and parents of young girls properly. Women's action groups and assertiveness training classes should learn to teach women what to do in a threatening situation, how to relate to the police and what new legislation is needed.

The careful explanation and interpretation of the many scientific data makes them easily understandable; the bibliography is comprehensive and helpful. Dr. Hursch's writing style flows easily. The reader will not feel coerced, intimidated or threatened because the author presents a sensitive subject in a logical fashion. I highly recommend "The Trouble With Rape" to all readers — professional, men, women, parents, teachers, and students.

Richard E. Gordon, M.D.
Tampa

Dr. Gordon is Director of the Florida Mental Health Institute, Department of HRS, Tampa.

Sleep Disturbance and Hypnotic Drug Dependence edited by Anthony D. Clift, M.D. 352 Pages. Illustrated. Price \$35.95. Excerpta Medica, Amsterdam, The Netherlands, 1975.

This book offers a deep and broad overview of sleep physiology, pathology and most specifically, correct treatment and the abuses of treatment in sleep disorders.

Combining the work of researchers in the United States, England, and Australia, the editor directs this volume at the primary physician who is presented each day of practice with complaints referable to sleep. The use of hypnotics of all types is carefully reviewed. Drug abuse in the form of "mild dependency" (nightly doses) is commonplace in spite of the fact that only during the initial days of administration for insomnia is benefit accrued.

An attempt is made to impress the clinician that hypnotics are only stop-gap measures of transient benefit in treatment of insomnia while the underlying medical, surgical, or psychiatric problem is receiving more specific management. In all studies the elderly are especially abuse-prone and particularly susceptible to intoxication due to impaired metabolic function in major excretory systems.

In sum, the text covers much ground from basic sleep research to its clinical application. Throughout there are ample diagrams and tables, frequent case histories and an impressive bibliography after each chapter. This volume would be a fine addition to a medical library if only to remind the physician again of his responsibility in prescribing addictive medication.

Harry W. Eichenbaum, M.D.
St. Petersburg

Dr. Eichenbaum is in the private practice of Internal Medicine in St. Petersburg.

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Books Received

Receipt of the following books is acknowledged. Medical readers interested in reviewing particular books are invited to address requests to the Book Review Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.

Healthy Pregnancy — The Yoga Way by Judi Thompson (Foreword by James C. Baker, M.D.). 148 Pages. Illustrated. Price \$3.95. Doubleday & Company, Inc., Garden City, New York, 1977.

BT Behavior Therapy, Strategies for Solving Problems in Living by Spencer A. Rathus, Ph.D. and Jeffrey S. Nevid, Ph.D. 314 Pages. Illustrated. Price \$8.95. Garden City, New York, Doubleday & Company, 1977.

Income Redistribution, edited by Colin D. Campbell. 267 Pages. Price \$4.75 (paperback) \$9.75 (cloth). Washington D. C., American Enterprise Institute for Public Policy Research, 1977.

Handbook for Differential Diagnosis of Neurologic Signs and Symptoms by Kenneth M. Heilman, M.D., Robert T. Watson, M.D. and Melvin Greer, M.D. 231 Pages. Illustrated. Price \$8.95. New York, Appleton-Century-Crofts, 1977.

Psychosomatic Aspects of Allergy by Claude A. Frazier, M.D. 257 Pages. Illustrated. New York, Van Nostrand Reinhold, 1977.

Stuttering Solved by Martin F. Schwartz, Ph.D. 186 Pages. Price \$3.50. New York, McGraw-Hill Paperbacks, 1976.

Controlling Health Care Costs, Strengthening the Private Sector's Hand by Clark C. Havighurst. 29 Pages. Price 35¢. Washington D. C., American Enterprise Institute, 1977.

Labor & Delivery, An Observer's Diary by Constance A. Bean with an introduction by Gerald Cohen, M.D., 203 Pages. Price \$7.95. Garden City, New York, Doubleday & Company, 1977.

Review of Physiological Chemistry, 16th Ed. by Harold A. Harper, Ph.D., Victor W. Rodwell, Ph.D. and Peter A. Mayes, Ph.D., D.Sc. 681 Pages. Price \$13.00. Los Altos, Calif., Lange Medical Publications, 1977.

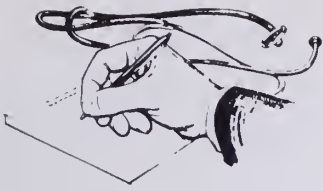
Child Health in the Community, edited by Ross G. Mitchell, M.D. 313 Pages. Price \$18. New York, Churchill Livingstone, 1977.

Medicine in the Tropics, Diagnostic Pathways in Clinical Medicine, An Epidemiological Approach to Clinical Problems by B. J. Essex. 173 Pages. Illustrated. Price \$9.95. New York, Churchill Livingstone, 1976.

Controlled Substances Inventory List, by the United States Department of Justice, Drug Enforcement Administration. 293 Pages. Washington, D. C., 1977.

Handbook of Obstetrics & Gynecology, 6th Ed. by Ralph C. Benson, M.D. 772 Pages. Illustrated. Price \$9.50. Los Altos, Calif., Lange Medical Publications, 1977.

Love and Sex in Plain Language, Third Revised Ed. by Eric W. Johnson. 143 Pages. Illustrated. Price \$6.95. New York, J. B. Lippincott Company, 1977.



Others Are Saying

Obesity (Exogenous) Is Not A Medical Problem

This article, as you will soon discern, is a somewhat different type of discussion of the nonmedical, personal problem of exogenous obesity. Let's begin with a few dictionary definition:

1. Obesity: "A condition in which excessive fat is stored in the body due to a positive energy balance."

2. Endogenous Obesity: "Those conditions of overweight where internal factors such as endocrine glands or subcortical mid-brain structures are involved."

3. Exogenous Obesity: "Due to an external cause not arising within the organism."

Any qualified generalist M.D., via a thorough medical history and physical examination with a minimum of reasonably inexpensive laboratory tests, can promptly establish whether the overweight patient has endogenous obesity. Should this obtain, there is a formal and medically valid approach and rationale for treatment. The theme of this article relates to the physician's role after his conclusion that the patient's problem is not due to abnormal physiology; it proposes that the issue is then no longer "medical" and the physician should be spared the thankless and time wasteful task of helping erroneously labeled "patients" solve or end their bad eating habits. The magnitude of the problem is reflected in the following 1970 statistics which revealed that there were approximately 50 million obese Americans (that is anyone who has more than 20% of his total body weight composed of fat) and that, aside from medical services, these individuals spent more than several billion dollars on ineffective diets, devices and bad advice.

Let me clarify. I do not mean that physicians should withdraw their services from treating those myriad of medical and surgical illnesses and complications resulting directly from obesity (i.e., cardiovascular, cardiopulmonary, surgical, surgical

morbidity, diabetes, etc.) nor am I suggesting that they discontinue their extraordinarily complex and needful efforts in nutritional research.

Perhaps this analogy will prove helpful; whereas it is unthinkable to imagine that emergency room physicians, surgeons and other specialists would not bring a vast array of medical expertise and technology to treating the victims of automobile accidents, even those caused by drunk and otherwise self-destructive drivers, it does not follow that highway safety, design of automobiles, or driver education programs are proper places for physicians' services. Wait, you caution; the analogy is a poor one because questions of proper nutrition are true medical issues. My reply to this is as follows: Yes, in those turn of the century days when minimal daily requirements of carbohydrates, fats, proteins, vitamins, and minerals were first exposed to scrutiny and assessment, the medical leadership was crucial in defining and treating malnutrition. However, as is so often the case in the history of science, once the discoveries are made in medical research, the medical experts must turn to new horizons while other technologists come in to implement their discoveries.

No Need to Consider What is Already Known to Most Laymen as Medical Therapy

What I am suggesting is that there is no longer a need for professional investigation into the more subtle aspects of human nutrition or that men of research capability, with the advantage of the new technologies, should not devote themselves to researching the problems of weight and its accompanying morbidity. But to take general men of medicine out of the main stream of treating sick patients to merely apply what is already known to any layman is a tragic misuse and misappropriation of a rare and precious commodity in our society, i.e., the physician. The latest estimates allow that

there are between five and seven thousand M.D.'s and D.O.'s who limit themselves or focus their practices on so-called weight control or bariatric medicine, and in 1970 the FDA established that between five and ten million patients per year were treated by these "specialists" who are alleged to have dispensed two billion diet pills at close to a half-billion dollars in prescription fees. (a fact which was investigated by a U.S. Senate antitrust committee in that same year).

Please do not misconstrue this admonition as a denial of the vital role we physicians have in public health or preventive medicine, i.e., inoculating ghetto children against diphtheria, mass screenings for diabetes, tuberculosis and cancer of the cervix, spraying swamps against malaria-carrying mosquitos and other parasites and insisting upon sanitation of water, pasteurization of milk and antiseptic precautions on obstetrical and surgical procedures, but in no way can these services be compared to the endless and wasteful enterprise of thousands of physicians cajoling, exhorting, persuading, and supplicating literally millions of obese individuals to quit eating stupidly, while at the same time often prescribing thyroid, amphetamine, diuretics and appetite suppressant medications which create an artificial environment for all body cells such as to deceive and countermand normal metabolism (with short and long term biological sequelae inadequately researched) and, in some instances, compounding the error by violation of that first medical tenet — treatment without thorough examination.

To the allegations stated earlier, i.e., referring to obese individuals as people who eat stupidly, some of my psychiatrist colleagues, I am sure, prefer to restate this by saying that anyone who eats as irrationally as most fat people must be neurotic and I guess if any physician is, in fact, right for the job of treating the obese patient, it is the psychiatrist. Yet, though it is true that the discipline of psychiatry has set itself the task of evaluating and treating irrational self-destructive behavior in all its forms and ramifications, it is a parallel and perhaps more compelling truth that the state hospitals and child and adult community mental health centers operate with shamefully inadequate physician-patient ratios. This, in the face of the facts, (1) that there are some things that only M.D. psychiatrists can do, and (2) that there are some things that M.D. psychiatrists and well-qualified others can do, i.e., social workers, psychologists, lay therapists . . . it makes good sense, does it not, to pass the fiefdom of the

irrational habits of over-eating, over-drinking and smoking to others.

In these days when M.D. shortages and quality of physician care is debated in every forum, state and national legislature, it is exquisitely appropriate for us physicians ourselves to be the first to advise our patients what are the injudicious, inappropriate or over-zealous utilizations of precious and rare medical expertise. This same point was affirmed in a recent speech by the president elect of the Florida Medical Association when he cited the myriad of problems created for the medical profession by alcoholism, obesity, vehicular accidents, drug abuses, suicide attempts and gestures, and beatings. He conveyed his argument as an appeal to the community to recognize that if our society did something to counteract the social causes of physical illness and breakdown such as poverty, pollution, malnutrition, poor prenatal care, and other inadequate social and public health programs, then perhaps the physicians already available or on the horizon of new medical school graduations in the forthcoming years could easily be distributed in a favorable way to care for the remaining sick and infirm members of our society.

The Simple and Direct Answer

What then, you may rightfully ask, should the physician say when he has discovered that his overweight patient has exogenous obesity? The answer is direct and simple:

Here is a pamphlet prepared by the United States Government printing office identifying minimal daily requirements of vitamins, minerals, carbohydrates, fats and protein, and also resulting calories per serving of most foods which you are likely to ingest.

The mathematics of weight reduction can easily be worked out by figuring how much fat your body must then burn to account for the difference between calories ingested and energy expended. Average and usual energy expenditures are also estimated in other tables in the same pamphlet.

My whole point here is that good advice on weight reduction is a one visit, at most, medical situation which follows the full physical and laboratory examination. All else is nonmedical commentary.

Alfred E. Fireman, M.D.
Seminole

Hollis G. Boren, M.D., . . . has been appointed by the Florida Board of Regents as Director of the University of South Florida Medical Center in Tampa and Dean of the USF College of Medicine.



Dr. Boren had held the dual positions for several months on an acting basis since the resignation of Donn L. Smith, M.D., who returned to teaching duties at the College.

A member of the USF College of Medicine faculty since 1972, Dr. Boren has served as Assistant Director of the

Medical Center and Associate Dean of the College of Medicine under Dr. Smith.

"Dr. Boren had strong support not only from the University but from the medical community at large," according to USF President Reece Smith. "After working with Dr. Boren this past year, I am confident he will bring able leadership to the College of Medicine."

A native of Texas, Dr. Boren received his M.D. degree from Baylor. He was on the faculty there, as well as at the University of Colorado Medical Center and the Medical College of Wisconsin.

He is the author of a number of medical related articles and has authored several textbook chapters.

The Medical Education Committee . . . of the Florida Medical Foundation has been accredited by the American Medical Association for continuing medical education.

Accreditation was made provisional for a one-year period beginning May 6, 1977. In granting accreditation, the AMA Council on Medical Education acted favorably on a recommendation by the FMA Committee on Continuing Medical Education, which conducted a "site survey in reverse" of the Foundation committee last May 6.

As an accredited organization, the FMF Committee, headed by Robert H. Threlkel, M.D., of Jacksonville, is authorized to designate and sponsor or co-sponsor AMA Category I programs.

At its recent meeting the AMA Council also voted to reaccredit the CME program of the South Florida Psychiatric Society for two years.

An Indiana physician . . . has been appointed Professor and Chairman of the Department of Family Medicine at the University of South Florida College of Medicine in Tampa.

He is Ronald G. Blankenbaker, M.D., currently Director of the Family Practice Residency Program at Methodist Hospital in Indianapolis. He will assume the Florida position in mid-October.

Dr. Blankenbaker succeeds D. Robert Howard, M.D., who left the College in June to develop the family practice program at the new University of Wyoming School of Medicine. In the interim, Charles E. Aucremann, M.D., of St. Petersburg, has been serving as acting chairman.

Dr. Blankenbaker is a graduate of the University of Indiana School of Medicine and also holds a Master of Science degree in pharmacology. He is a Diplomate of the American Board of Family Practice and a Fellow of the American Academy of Family Physicians.

The American College of Physicians . . . will conduct its Florida Regional Meeting in Sarasota in October.

The session will be at the Colony Beach Club on Long Boat Key, October 14-15. Information may be obtained by contacting Charles K. Donegan, M.D., 501 11th Street North, St. Petersburg 33705.

The First International Congress . . . on Colonoscopy and Diseases of the Large Bowel will be held March 2-4, 1978 at the Fontainebleau Hotel in Miami Beach.

The program will include 15 speakers and about 100 scientific papers. Information may be obtained by contacting John P. Christie, M.D., Program Chairman, Suite 311, 7400 North Kendall Drive, South Miami, Florida 33156.

Meetings

Approved by FMA Committee on Continuing Medical Education

OCTOBER

Topics in Family Medicine, Oct. 3-7, Americana Hotel, Bal Harbour. For information: Elliott Podoll, M.D., P.O. Box 520875, Miami 33152.

Third Panamerican Seminar, Oct. 3-7, Mount Sinai Medical Center, Miami Beach. For information: Office of CME, 4300 Alton Road, Miami Beach 33140.

Update of Diabetes, Oct. 6, University Health Center, Tallahassee. For information: Philip O. Rond, M.D., University Health Center, Tallahassee 32306.

Current Concepts and Treatment in Cerebrovascular Disease, Physiologic Basis for Central Nervous System Pacemakers and Current Concepts on Senility, Aging and Parkinson's Disease, Oct. 6-8, Naples Bath and Tennis Club, Naples. For information: Allan Herskowitz, M.D., 115 N.W. 167th St., Suite 302, North Miami Beach 33169.

Obstetrics and Gynecology Review Course, Oct. 8-14, Miami.*

Review Course on "Fundamental and Clinical Aspects of Internal Medicine," Oct. 9-22, Sheraton Four Ambassadors, Miami. For information: J. Bocles, M.D., Department of Medicine, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152.

6th Family Practice Review, Oct. 10-14, Gainesville Hilton, Gainesville.**

Use and Abuse of Blood and its Components, Oct. 11, Manatee Memorial Hospital, Bradenton. For information: Allen R. Sklerov, M.D., 525-3rd Street, East, Bradenton 33505.

Negotiations, Oct. 12, Peace River Country Club, Bartow. For information: Gwen Conner, M.D., P.O. Box 927, Lakeland 33802.

Florida Urological Society annual fall meeting, Oct. 13-16, Ponte Vedra Club, Ponte Vedra. For information: Raymond J. Fitzpatrick, M.D., 706 S. W. 4th Ave., Gainesville 32601.

"Practical Endocrinology," Oct. 14-15, The Casino, Pensacola Beach. For information: R. Douglas Collins, M.D., 1000 West Moreno St., Pensacola 32501.

*For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152, Tel. (305) 547-6716.

**For Information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143.

+For Information: Contact Theron A. Ebel, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2074.

Florida Society of Internal Medicine and American College of Physicians, Florida Region, Oct. 14-16, Colony Beach and Tennis Resort, Long Boat Key.

Obstetrics and Gynecology Review Course: Pathology Section, Oct. 15-16, Miami.*

OB-GYN Culposcopy Course, Oct 17-19, Miami.*

Common Skin Problems in the College Community, Oct. 20, University Health Center. For information: Philip Rond, M.D., University Health Center, Tallahassee 32306.

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Oct. 24-29, Miami.*

Medico-Legal Aspects of Medicine, Oct. 27, University Health Center, Tallahassee. For information: Philip Rond, M.D., University Health Center, Tallahassee 32306.

Interstate Scientific Assembly, Oct. 31-Nov. 3, Diplomat Hotel, Hollywood. For information: Alton Ochsner, M.D., Post Office Box 1109, Madison, Wisconsin 53701.

NOVEMBER

Venereal Disease: The Laboratory, Nov. 3, University Health Center, Tallahassee. For information: Philip Rond, M.D., University Health Center, Tallahassee 32306.

Fall Meeting of the Florida Society of Ophthalmology, Nov. 3-6, Sandpiper Bay, Port St. Lucie, Florida. For information: Susan Waits, Suite 400G, Barnett Bank Building, Tallahassee 32301.

Trauma Symposium, Nov. 5-6, North Ridge Hospital, Fort Lauderdale. For information: Edgar H. J. Hift, M.D., 5757 North Dixie Highway, Fort Lauderdale 33334.

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Nov. 7-12, Miami.*

Seventh George Papanicolaou Memorial Seminar, Nov. 9, Dallas, Texas. For information: George Ioannides, M.D., Dept. of Path., St. Francis Hospital, Miami Beach 33141.

Pars Plans Vitreous Surgery - The Miami Technique, Nov. 10-12, Miami.*

Antibiotic Selection and Use, Nov. 11, Veterans Administration Center, Bay Pines. For information: John C. Gallagher, M.D., Veterans Administration Center, Bay Pines 33504.

The Eye in Family Practice, Nov. 11-12, Miami.*

Knee Injuries and the College Student, Nov. 17, University Health Center, Tallahassee. For information: Philip Rond, M.D., University Health Center, Tallahassee 32306.

Clinical Application of the Intra-Aortic Balloon Pump, Nov. 25-27, Miami.*

DECEMBER

Laparoscopy: Diagnostic and Therapeutic Techniques, Dec. 1-3, Contemporary Resort Hotel, Lake Buena Vista. For information: H. Worth Boyce, Jr., M.D., 12901 North 30th St., Tampa 33612.

Basic Clinical Electrocardiography and Arrhythmia Management, Dec. 2-4, Royal Biscayne, Miami. For information: William E. James, Ph.D., One Inverness Drive, Englewood, Colorado 80110.

The Vitreous, Dec. 7-9, Miami.*

Pediatric Anesthesia, Dec. 8-11, Miami.*

Medical Surgical Seminar, Dec. 9-10, St. Francis Hospital, Miami Beach. For information: Lawrence R. Medoff, M.D., 250 West 63rd Street, Miami Beach 33141.

5th Annual Symposium on the Management of Sexual Problems, Dec. 9-11, Gainesville Hilton, Gainesville.**

Intraocular Lenses, Dec. 12-15, Miami.*

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Dec. 12-17, Miami.*

1978

JANUARY

Fifth Annual Symposium in Pediatric Nephrology: Current Concepts in Diagnosis and Management, Jan. 4-7, Miami.*

Fifteenth Annual Postgraduate Seminar in Anesthesiology, Jan. 5-8, Americana Hotel, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

Miami Winter Symposia, Jan. 9-12, Miami.*

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Jan. 9-14, Miami.*

Third Annual Seminary, "Problems in Pediatric Radiology", Jan. 13-17, Miami.*

3rd Annual Seminar "Problems in Pediatric Radiology", Jan. 13-17, Sonesta Beach Hotel and Tennis Club, Key Biscayne.*

Postconvention Seminar in Pediatric Radiology "Radiographic-Pathologic Correlation of Pediatric Diseases", Jan. 17-20, The Colony Beach and Tennis Resort, Sarasota.*

Art and Science in the Therapy of Difficult Problems in Surgery, Jan. 18-21, Miami.*

10th Annual Postgraduate Seminar in Pediatric & Adult Urology, Jan. 19-21, Carillon Hotel, Miami Beach. For information: Victor Politano, M.D., 3900 Northwest 79th Ave., Suite 469, Miami 33166.

Corneal and Plastic Ophthalmic Surgery and Diseases of the Eye, Jan. 22-27, Miami.*

3rd Annual Review and Recent Practical Advances in Pathology, Jan. 23-27, Miami.*

A Neurological Update: 1978, Jan. 23-27, Miami.*

3rd International Symposium on Stress, Jan. 26-27, Gainesville Hilton, Gainesville.**

Cancer Chemotherapy, Jan. 27, Veterans Administration Center, Bay Pines. For information: John C. Gallagher, M.D., Veterans Administration Center, Bay Pines 33504.

Coronary Disease, Exercise, Testing and Cardiac Rehabilitation, Jan. 27-29, Orlando Hyatt House, Orlando. For information: William E. James, Ph.D., One Inverness Dr., Englewood, Colorado 80110.

Thirteenth Annual Scientific Assembly of the American Society of Contemporary Medicine and Surgery, Jan. 30-Feb. 3, Americana Hotel, Miami Beach. For information: John G. Bellows, M.D., 6 North Michigan Avenue, Chicago 60602.

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FEBRUARY

23rd Central Florida Medical Meeting, Feb. 3-5, Contemporary Resort Hotel, Orlando. For information: Edward Ackerman, M.D., 800 West Morse Blvd., Winter Park 32789.

Fourth Annual Vail Conference in Anesthesiology, Feb. 4-11, Miami.*

OB-GYN Caribbean Seminar, Feb. 4-11, Miami.*

Clinical Nephrology and Hypertension, Feb. 6-8, Doral Beach Hotel, Miami. For information: Office of CME Mount Sinai Medical Center, 4300 Alton Road, Miami Beach 33140.

Florida Midwinter Seminar in Ophthalmology, Feb. 6-8, Miami.*

13th Annual "Internal Medicine 1978," Feb. 6-11, Miami.*

Florida Midwinter Seminar in Otolaryngology, Feb. 9-11, Miami.*

Principles of Practice Management, Feb. 12-18, Miami.*

Basic Clinical Electrocardiography and Arrhythmia Management, Feb. 17-19, Bahia Mar, Fort Lauderdale. For information: William E. James, Ph.D., One Inverness Drive, Englewood, Colorado 80110.

Pediatric Dermatology Seminar, Feb. 23-26, Konover Hotel, Miami Beach. Program to be followed by a one week post seminar flight and cruise to the Caribbean and South America. For information: Guinter Kahn, M.D., 16800 N.W. 2 Ave., Suite 401, N. Miami Beach 33169.

Basic Neurology for Psychiatrists, Family Practitioners and General Practitioners, Feb. 26-Mar. 3, Miami.*

MARCH

Hepatobiliary Disease in Clinical Practice, Mar. 2-4, Miami.*

5th Annual Selected Topics in Urology, Mar. 2-4, Gainesville Hilton, Gainesville.**

First International Congress on Colonoscopy and Diseases of the Large Bowel, Mar. 2-4, Fontainebleau Hotel, Miami Beach. For information: John P. Christie, M.D., 7400 N. Kendall Drive, Suite 311, S. Miami 33156.

Management of Diabetes Mellitus, Mar. 3, Veterans Administration Center, Bay Pines. For information: John C. Gallagher, M.D., Veterans Administration Center, Bay Pines 33504.

3rd Annual Conference in Skin Disorders for Nurses, Mar. 3-5, Miami.*

Postgraduate Seminar in Dermatology, Mar. 3-5, Miami.*

Eighth Annual Radiological Special Procedures Seminar, Mar. 4-7, Konover Hotel, Miami Beach. For information: Mrs. Lucy Kelley, 6752 S.W. 34th Court, Miramar 33023.

16th Annual Clinical Radiology Seminar "Controversies in Radiology," Mar. 7-11, Konover Hotel, Miami Beach. For information: Mrs. Lucy Kelley, 6752 S.W. 34th Court, Miramar 33023.

2nd Annual Seminar "Practical Aspects of Computed Tomography, Mar. 12-15, Konover Hotel, Miami Beach.*

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Mar. 13-18, Miami.*

Practical Aspects of Ultrasonography, Mar. 15-18, Konover Hotel, Miami Beach.*

Postconvention Seminar Bahamian Cruise, Mar. 17-20, Nassau, Bahamas.*

10th Teaching Conference in Clinical Cardiology, Mar. 22-25, Miami.*

Current Clinical Concepts in Otolaryngology, 1978, Mar. 22-24, Miami.*

9th Annual Topics in Internal Medicine, Mar. 23-25, Gainesville Hilton, Gainesville.**

APRIL

Malignant Hyperthermia, Apr. 6-9, Miami.*

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Apr. 10-15, Miami.*

Sixth Annual Intensive Care Symposium, Apr. 15-17, Miami.*

Emergencies in Internal Medicine, Apr. 17-20, Miami.*

Advanced Electrocardiography and Arrhythmia Management for the Family Practitioner, Apr. 20-22, Gainesville Hilton, Gainesville.**

MAY

Second Annual Symposium on Underwater Medicine, May 4-8, Miami.*

Seizure Disorders, May 5, Veterans Administration Center, Bay Pines. For information: John C. Gallagher, M.D., Veterans Administration Center, Bay Pines 33504.

Post-Convention Seminar and Diving Program, May 8-11, Miami.*

Pars Plana Vitreous Surgery - The Miami Technique, May 11-13, Miami.*

Family Medicine Update — 1978, May 18-21, Miami.*

7th Family Practice Review, May 22-26, Gainesville Hilton, Gainesville.**

JUNE

Review Course for Certification in Internal Medicine, June, Miami.*

Bascom Palmer Eye Institute Alumni Meeting and Seminar, June 9-11, Miami.*

Coronary Disease, Exercise Testing and Cardiac Rehabilitation, June 23-25, Orlando Hyatt House, Orlando. For information: William E. James, Ph.D, One Inverness Drive, Englewood, Colorado 80110.

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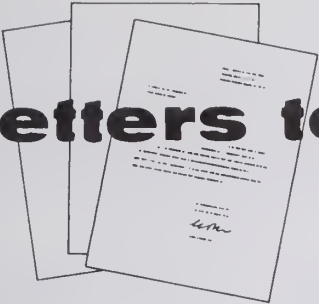
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Letters to the Editor

To the Editor: The image of organized medicine has steadily worsened over the past 20 years which could account for the **opening of low cost health testing centers** in the urban areas. In my opinion, there are many reasons for this situation some of which are listed below based on my experience as a physician/legislator.

1. The marked increase in the number of specialists locating in urban areas, often over and above existing patient needs.

2. The wide variation of fees charged by both specialists and nonspecialists for similar services. For example - the cost of routine **uncomplicated** surgery may vary by substantial amounts of monies.

3. Less time is being spent with patients and their families by attending physicians or surgical specialists to explain the need and costs for tests, treatments and surgical procedures. This may be the **major factor that has increased the number of malpractice cases throughout America.**

4. Some physicians do not accept assignments **routinely**, even if requested by patients living on Social Security payments only.

5. Some physicians are not present when consent forms are signed which may lead to misunderstandings by the patient or his family.

6. The overbuilding of hospitals, Nursing Homes, HMO's and ambulatory surgical centers which increases health care costs.

7. The purchase of expensive equipment by some health care providers when a need does not exist in the community.

8. Medicare and Medicaid fraud by some health care providers.

9. Lack of interest and time devoted to community problems by some physicians.

10. Failure to register to vote or not voting at all; nonparticipation in political campaigns, and not becoming knowledgeable regarding the important issues under discussion in these campaigns.

David J. Lehman, M.D.
State Representative, District 97
Hollywood

Dear Friends:

This farewell message brings to you my appreciation of the happiness you have given to me during my sojourn among you.

Your loyal friendship has illuminated my pathway in life and brought me peace.

May God bless you and keep you and bring you contentment to the end of your days.

I, who have loved the good earth, have no fear in being enfolded in her bosom. Hail and farewell. Embarked on the great adventure, May 19, 1977.

Garland M. Johnson, M.D.
Shaker Heights, Ohio

(Editor's Note: Dr. Johnson was a practicing ophthalmologist in Fort Lauderdale for several years prior to her retirement. The above letter was found among her papers after her death on May 19, 1977, at age 75 by her husband, Lorand V. Johnson, M.D.).

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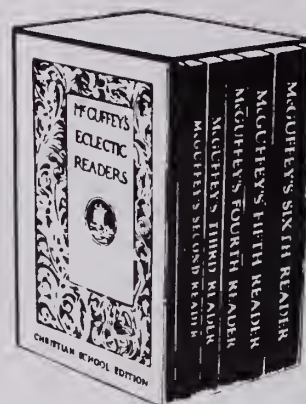


MICROVASCULAR SURGERY COURSES

The Microsurgical Education Center in the Division of Neurological Surgery at the University of Florida is offering two microvascular surgery courses lasting three days for thoracic and cardiovascular surgeons. The courses will be held in November and December, 1977.

For registration and further course information, write:

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Physicians who have not ordered their new Blue Shield Claim Forms are urged to do so immediately. When they receive their new supply of the new forms, they are asked to discard the old forms. The old forms (DSR's) were not acceptable after August, 1977.

Pre-printed Blue Shield Claims Forms also are available for those physicians desiring them. The different types of pre-printed forms (i.e., Solo Practice Physician, P.A. or Group Number, P.A. or Group Number with Individual Physician Number) were outlined in the March, 1977, issue of *Notes from Blue Shield (Special Edition)*. An order blank also was enclosed.

If you have questions about ordering your pre-printed forms, contact Mr. Michael O'Farrell, Manager, Physician Services, Blue Shield of Florida, Box 1798-F, Jacksonville 32231, telephone (904) 791-6601.

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EXCELLENT OPPORTUNITY FOR GENERAL PRACTITIONER OR WELL TRAINED INTERNIST with good background in cardiovascular diseases. Office and equipment available low rental in South Dade, South of Kendall. Call (305) 247-7435.

FAMILY PRACTICE—Excellent opportunity for physician to perform general practice in expanding North Florida community. Attractive 128-bed new hospital that provides excellent facilities for treatment. For additional information contact John E. Knight, Administrator, Lake Shore Hospital, Lake City, Florida 32055. Phone: (904) 752-2560.

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GASTROENTEROLOGIST AND ORTHOPEDIC SURGEON needed by multispecialty 20-man group in Aventura, North Miami Beach. This is a quality, fee-for-service group in private practice. Please visit our medical center and send curriculum vitae to The Aventura Medical Center, 2956 Aventura Boulevard, North Miami Beach, Florida 33180.

NEONATOLOGIST—Third full-time neonatologist needed for established Level III Neonatal Intensive Care Unit in Orlando, Florida. Active referral center with approved Pediatric Training Program. Beautiful Community with excellent recreational facilities. Please address inquiries to Keith S. Kanarek, M.D., Department of Pediatrics, Orange Memorial Hospital, 1416 South Orange Avenue, Orlando, Florida 32806.

36 YEAR OLD, BOARD CERTIFIED OTOLARYNGOLOGIST, seeking board certified or eligible associate. Practice encompasses all aspects of otolaryngology, facial plastic surgery, head and neck surgery, upper respiratory allergy. Located in Central Florida. Lakeland, 30 miles east of Tampa, on Florida's west coast. Attractive climate and recreational advantages. Prosperous growing community. Excellent early starting salary leading to early partnership. Please send curriculum vitae to: C-820, P.O. Box 2411, Jacksonville, Florida 32203.

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PSYCHIATRIST/G.P. PHYSICIAN—Openings are anticipated from time to time in well established Community Mental Health Center. Florida license required. This is a CMHC with four large programs: Drug Abuse Alcohol Counseling Center, Child Development Center and General Mental Health Program. Pensacola offers beautiful beaches and excellent recreational opportunities. No state income tax. Letters of inquiry, with resume, should be forwarded to Morris L. Eaddy, Ph.D., Executive Director, Community Mental Health Center of Escambia County, Inc., 1201 West Hernandez Street, Pensacola, Florida 32501. An equal opportunity employer.

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FAMILY PRACTITIONER OR INTERNIST wanted to share facilities with five practitioners in solo practice. Major equipment provided. Rent \$250.00 per month. Excellent laboratory and x-ray with income based on use. Bookkeeping system shared. Financial assistance available to right party. Contact T. C. Kenaston Jr., M.D., Box 550, Cocoa, Florida 32922.

WANTED: Physician to join several other physicians in emergency room practice in central Florida community hospital, 150 beds. Forty hour week. Benefits include 3 weeks vacation and 2 paid medical conferences. Starting salary \$40,000 yearly. Must be graduate of U.S. medical school, have AMA internship, and some previous practice desirable. Florida license necessary. Contact: James N. Kulpan, Administrator, Waterman Memorial Hospital, P.O. Drawer B, Eustis, Florida 32726. Phone: (904) 357-4161.

PUBLIC HEALTH OPENING IN PUTNAM COUNTY: Duties primarily general practice but no emergency, night or weekends. Dr. Dean Silvers, Box 1070, Palatka, Florida 32077. Phone (904) 328-5181.

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ORTHOPEDIC SURGEON, 30, married, university trained, available July 1978. Experienced in total joint replacement, desires partnership, group, or solo on Florida coast. American, Bilingual, Spanish-English. Write C-794, P.O. Box 2411, Jacksonville, Florida 32203.

ANESTHESIOLOGIST: ABA certified, U.S. needed, University trained, 14 years experience. Desires to relocate family in South Florida. Florida license. Write or call S. N. Smock, M.D., 3050 Foxcroft, Ann Arbor, Michigan 48104. Phone: (313) 973-2584.

PHYSICIAN, 55, twenty years experience in pathology, seeking to associate in family practice. Recently completed Harvard six-week course in internal medicine. Possessing Florida license. Curriculum vitae available upon request. Write C-818, P.O. Box 2411, Jacksonville, Florida 32203.

RADIOLOGIST—Board certified, desires full or part time association. Florida license. Write C-819, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST, 29, Boards pending, American trained, desires group practice or partnership starting July 1978. Refer West coast, north or central areas. John M. Thompson, M.D., 731 Woodward St., Charleston, S.C. 29407.

WANTED: Indiana University School of Medicine Physician Assistant, who will be graduated August 20, 1977, is seeking employment with an M.D. in a solo or group family practice in Florida in September 1977. Contact Dennis R. Newberg, 215 Elliott Avenue, Plymouth, Indiana 46563.

ORTHOPAEDIC SURGEON—board eligible, American graduate, looking for solo or group practice, available summer-fall, 1977. Write C-806, P.O. Box 2411, Jacksonville, Florida 32203.

OPHTHALMOLOGIST, 30, married, board qualified, university trained, desires opportunity in Florida. Write C-824, P.O. Box 2411, Jacksonville, Florida 32203.

BOARD CERTIFIED GENERAL PSYCHIATRIST, wide experience in private and public sector, Florida license. Seeks position as associate with individual, group or private hospital. Write C-826, P.O. Box 2411, Jacksonville, Florida 32203.

UROLOGIST, age 32, U.S. graduate, military service completed. Passed Part I urology boards, desires to relocate in Florida. Wishes to associate with group or partnership practice. Available December 1977. Write C-825, P.O. Box 2411, Jacksonville, Florida 32203.

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PATHOLOGIST-CERTIFIED CP/AP, 47, Florida licensed, native U.S., excellent C.V. and experience as director. Available on 2-3 months notice. Current post-grad. training and certification through 1980. Write: P.O. Box 11158, U.S. Post Office, 227 E. Ontario St., Chicago, Illinois 60611.

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For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days



- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice

- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. **CNS reactions:** Headache,

peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

***Pneumocystis carinii* pneumonitis:** Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

Her next attack of cystitis may require

the BactrimTM 3-system counterattack



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Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of

Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introital colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

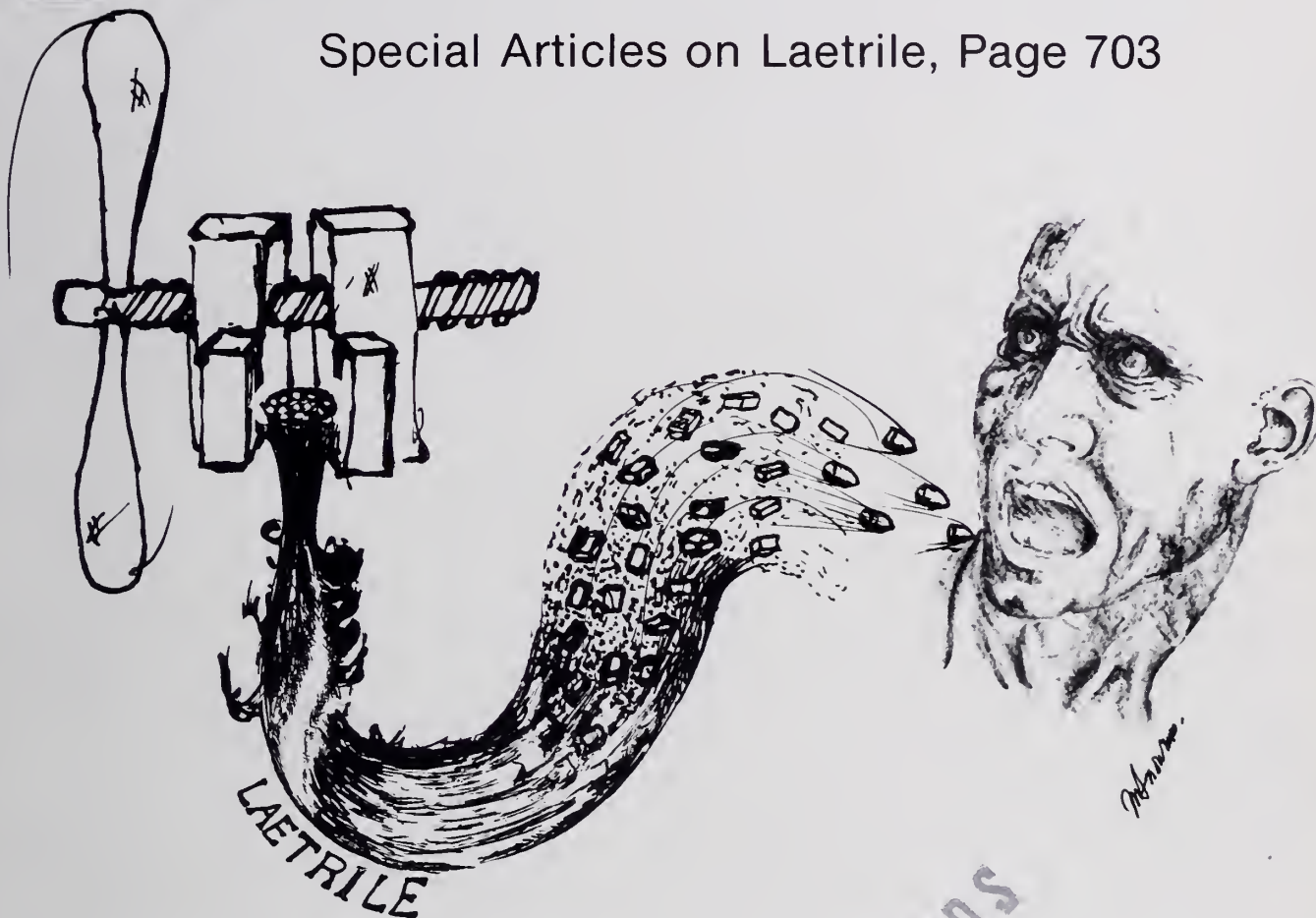
Bactrim fights uropathogens in the urinary tract/vagina

tract

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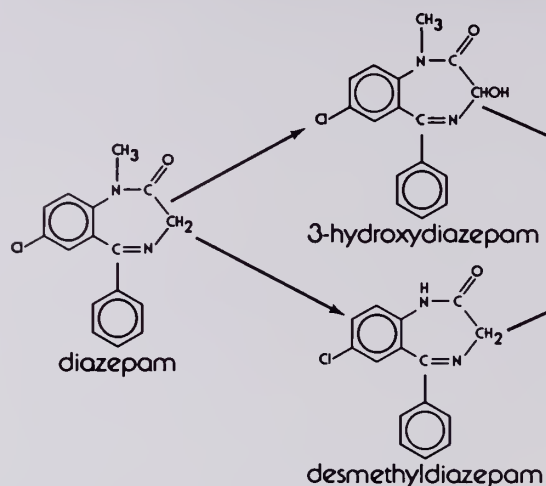


"Those present and future victims of cancer who will be lured away by the enticement of Laetrile from conventional cures for treatable cancer will be our burden," State Rep. Richard S. Hodes, M.D.

Journal Wins Prestigious Award, Page 720

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A pharmacokinetic character all its own



Valium (diazepam) is a benzodiazepine with a distinctive pharmacokinetic profile

The pharmacokinetic profile of Valium is one of the characteristics that sets it apart from other benzodiazepines. Consider, in particular, the metabolic pathway of Valium. The three major metabolites of Valium exhibit significant pharmacologic activity—and so, of course, does the parent substance—diazepam itself. All combine to produce the characteristic clinical response seen with Valium. The response you have come to know, to want and to trust.

Pharmacokinetic studies also demonstrate that Valium has a pattern of absorption, distribution, metabolism and elimination that is reliable and consistent. And, although the pharmacokinetics of a drug cannot, at present, be specifically related to its clinical effects, it is clearly a factor that distinguishes one product from another by providing important insights into how each moves through the patient's body.

Valium® (diazepam) ^{IV}

2-mg, 5-mg, 10-mg scored tablets
**a prudent choice in psychic
tension and anxiety**

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due

to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated:

Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma;

may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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Americana Hotel — Bal Harbour, Florida

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Monday, January 30: CARDIOVASCULAR DISEASES AND SURGERY Chairmen: Michael DeBakey and Eliot Corday. Speakers: Edward Beattie, Jr., Joel Morganroth, Alfred Persson, Domeena Renshaw, Albert Rhoton, Jr., Max Sadove, George Sybert, Henry Wagner, Jr., Robert Wallace, David Webb-Johnson.

Tuesday, January 31: CARDIOVASCULAR DISEASES (continued). Speakers: Leon Resnekov, Philip Samet, Bernard L. Segal, David Sheps, Ruey Sung, Henry Wagner, Jr. **HYPERTENSION** Chairman: John Laragh. Speakers: Frank Finnerty, Jr., James Hunt, Norman Kaplan, David Lowenthal, Robert Maronde. **PULMONARY DISEASES** Speakers: Maurice Segal, James Tennenbaum. **COSMETIC SURGERY** Chairman: Pierre Guibor. Speakers: Howard Beale, Crowell Beard, Richard Coburn, Frank Gillen, Robert Simons, Dowling Stough.

Wednesday, February 1: INFLAMMATORY BOWEL DISEASE Chairman: Joseph Kirsner. Speakers: Richard Farmer, Henry Janowitz, Martin Kalser, Burton Korelitz, Rene Menguy, Albert Weinfeld. **COMMON GASTROINTESTINAL PROBLEMS** Chairman: Arvey I. Rogers. Speakers: Jamie Barkin, Frank DeLand, Vicente Dinoso, Jr., Michael Levitt, Armand Littman, Albert Mendeloff, Daniel Paloyan, Herbert Sarett.

Thursday, February 2: CANCER Chairman: Joseph Painter. Speakers: Edward Beattie, Jr., William Cahan, Philip Exelby, Alfred Fracchia, Laurence Gardner, Ariel Hollinshead, Alfred Ketcham, Joe Levi, Alan Livingstone, Ralph Marcove, James Ozenberger, George Prout, Jr., Gerald Rosen, Charles Vogel, Horace Whiteley, Jr., C. Gordon Zubrod.

Friday, February 3: GENITOURINARY DISEASES Chairman: George Prout, Jr. Speakers: William Fair, T. W. Hensle, Gerald Mandell, Staffan Nordqvist, M. J. Vernon Smith, Louis Weinstein.

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Morton L. Hammond, M.D.

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OCTOBER COVER — We are grateful to Dr. John W. Snow, a practicing plastic surgeon in Jacksonville, for the cover art which illustrates the making of Laetrile from apricot pits and the fact that Laetrile can be harmful in that the patient's discontinuance of conventional chemotherapy is illustrated by its metamorphosis into bullets.

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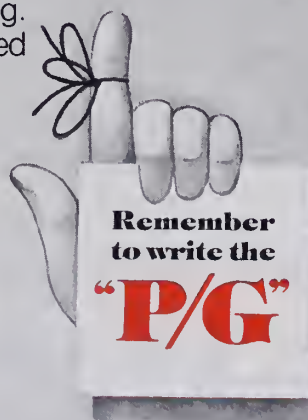
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See Clinical Considerations section on following page.



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Clinical Considerations: INDICATIONS FULVICIN P/G Tablets are indicated for the treatment of ringworm infections of the skin, hair, and nails, namely: tinea corporis, tinea pedis, tinea cruris, tinea barbae, tinea capitis, tinea unguium (onychomycosis) when caused by one or more of the following genera of fungi: *Trichophyton rubrum*, *Trichophyton tonsurans*, *Trichophyton mentagrophytes*, *Trichophyton interdigitalis*, *Trichophyton verrucosum*, *Trichophyton megnini*, *Trichophyton gallinae*, *Trichophyton crateriform*, *Trichophyton sulphureum*, *Trichophyton schoenleinii*, *Microsporum audouinii*, *Microsporum canis*, *Microsporum gypseum*, and *Epidermophyton floccosum*.

Note: Prior to therapy, the type of fungi responsible for the infection should be identified.

The use of this drug is not justified in minor or trivial infections which will respond to topical agents alone.

Griseofulvin is not effective in the following: Bacterial infections, Candidiasis (Moniliasis), Histoplasmosis, Actinomycosis, Sporotrichosis, Chromoblastomycosis, Coccidioidomycosis, North American Blastomycosis, Cryptococcosis (Torulosis), Tinea versicolor, and Nocardiosis.

CONTRAINDICATIONS This drug is contraindicated in patients with porphyria, hepatocellular failure, and in individuals with a history of hypersensitivity to griseofulvin.

WARNINGS Prophylactic Use: Safety and efficacy of griseofulvin for prophylaxis of fungal infections have not been established.

Animal Toxicology Chronic feeding of griseofulvin, at levels ranging from 0.5-2.5% of the diet, resulted in the development of liver tumors in several strains of mice, particularly in males. Smaller particle sizes result in an enhanced effect. Lower oral dosage levels have not been tested. Subcutaneous administration of relatively small doses of griseofulvin once a week during the first three weeks of life has also been reported to induce hepatomata in mice. Although studies in other animal species have not yielded evidence of tumorigenicity, these studies were not of adequate design to form a basis for conclusions in this regard.

In subacute toxicity studies, orally administered griseofulvin produced hepatocellular necrosis in mice, but this has not been seen in other species. Disturbances in porphyrin metabolism have been reported in griseofulvin-treated laboratory animals. Griseofulvin has been reported to have a colchicine-like effect on mitosis and cocarcinogenicity with methylcholanthrene in cutaneous tumor induction in laboratory animals.

Usage in Pregnancy The safety of this drug during pregnancy has not been established.

Animal Reproduction Studies It has been reported in the literature that griseofulvin was found to be embryotoxic and teratogenic on oral administration to pregnant rats. Pups with abnormalities have been reported in the litters of a few bitches treated with griseofulvin. Additional animal reproduction studies are in progress.

Suppression of spermatogenesis has been reported to occur in rats, but investigation in man failed to confirm this.

PRECAUTIONS Patients on prolonged therapy with any potent medication should be under close observation. Periodic monitoring of organ system function, including renal, hepatic, and hematopoietic, must be done.

Since griseofulvin is derived from species of penicillin, the possibility of cross sensitivity with penicillin exists, however, known penicillin-sensitive patients have been treated without difficulty.

Since a photosensitivity reaction is occasionally associated with griseofulvin therapy, patients should be warned to avoid exposure to intense natural or artificial sunlight. Should a photosensitivity reaction occur, lupus erythematosus may be aggravated.

Griseofulvin decreases the activity of warfarin-type anticoagulants so that patients receiving these drugs concomitantly may require dosage adjustment of the anticoagulant during and after griseofulvin therapy.

Barbiturates usually depress griseofulvin activity, and concomitant administration may require a dosage adjustment of the antifungal agent.

ADVERSE REACTIONS When adverse reactions occur, they are most commonly of the hypersensitivity type, such as skin rashes, urticaria, and rarely, angioneurotic edema, and may necessitate withdrawal of therapy and appropriate countermeasures. Paresthesias of the hands and feet have been reported rarely after extended therapy. Other side effects reported occasionally are oral thrush, nausea, vomiting, epigastric distress, diarrhea, headache, fatigue, dizziness, insomnia, mental confusion, and impairment of performance of routine activities.

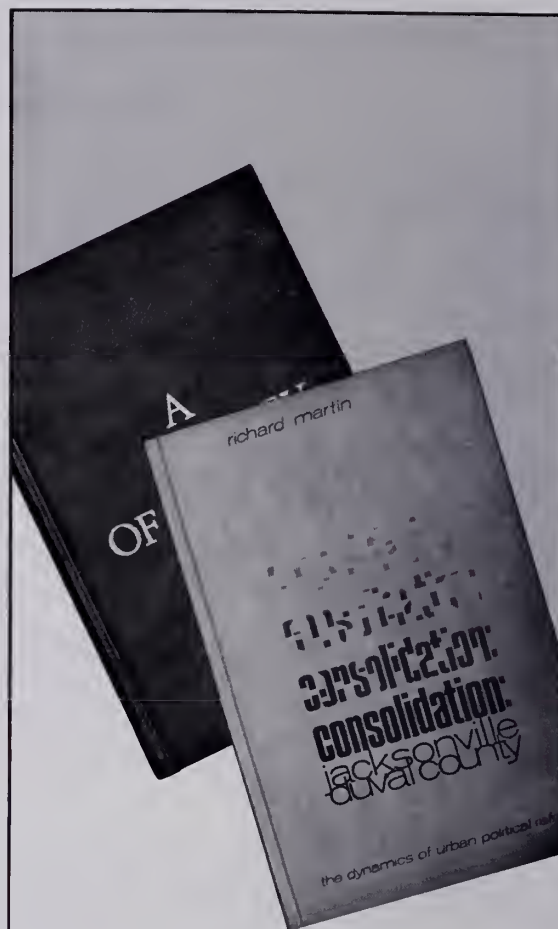
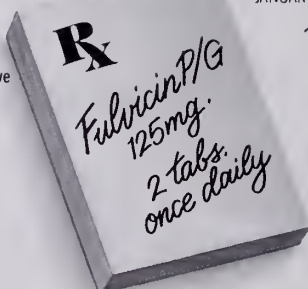
Proteinuria and leukopenia have been reported rarely. Administration of the drug should be discontinued if granulocytopenia occurs.

When rare, serious reactions occur with griseofulvin, they are usually associated with high dosages, long periods of therapy, or both.

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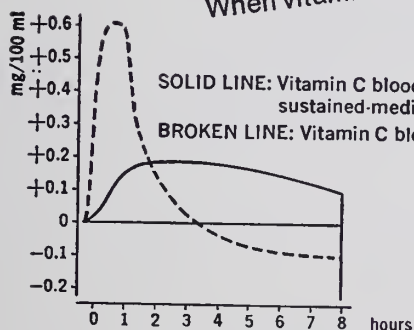
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*Comparison of ascorbic acid blood levels after administration of 1 gram of ascorbic acid in effervescent tablet form and 1 gram of CEVI-BID (2 capsules).

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¹ Riccitelli, M. L.: Vitamin C Therapy in Geriatric Practice, J. Amer. Geriatrics Soc. 20: 34, 1972.

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Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

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Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

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PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy—and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information

is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA

THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
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Dean's Page

U. S. Citizens in Foreign Medical Schools

Hollis G. Boren, M.D.

The phrase U. S. citizens in Foreign Medical Schools is used in the new Health Manpower Bill to identify a group of students which is a proper cause of major concern to many people. These students are a source of anxiety to parents, legislators, medical educators, and participating physicians alike. For members of the Florida Medical Association concern may arise in a variety and multiplicity of ways. These students may be our own children. They may represent a presumed threat to our children who are applicants for or who are already in our medical schools. Their ability to satisfactorily complete a medical education or to become competent peers in the practice of medicine are serious questions. Let me suggest that we make no prejudgements, that we become informed on the basic facts of the Health Manpower Bill and its implications and that then as best we may look for solutions for problems that confront all of us by the U. S. citizens in Foreign Medical Schools.

The Health Manpower Bill allows the Secretary of HEW to assign a quota of students in foreign medical schools who have passed Part I of the National Board of Medical Examiners to medical schools in the United States. Our medical schools may **not** use undergraduate academic performance, scores of the Medical College Aptitude Test, scores on Part I of the National Board of Medical Examiners, performance in foreign medical schools, state of residents, or letters of recommendation regarding academic ability as a basis to refuse to accept students! The bill goes on to say that "all other usual criteria for admission may be used." These students must be admitted to our schools beyond the "first academic year."

At this point one must wonder what the clout is that could possibly force any reputable medical school to relinquish its responsibility to use its resources on the best possible candidates to become competent physicians. The first result of refusal to comply with this bill is the loss of capitation funds. These funds have been used to induce medical schools to increase the size of their classes and their number of graduates. Although capitation funds have been appropriated in sufficient amounts to award funds equal to the full entitlement, they have been valuable to many private medical schools and have relieved some of the fiscal pressure on state supported schools.

It is on this point that I believe we face a danger as a profession of projecting a false public image. If we are viewed as simply lowering our students for federal dollars, our credibility as physicians suffers.

Dr. Boren is Director of the University of South Florida Medical Center and Dean of the College of Medicine, Tampa.

The real issue is the loss of funds for our own medical students if we do not accept students assigned by the Secretary of HEW. We do not have enough student loan funds for all of our students to be able to stay in medical school. A large part of the deficit will be met by the Federal Program of Insured Loans to Graduate Students in Health Professions Schools. These funds will not be available unless we comply with this new legislation. It would be our students who would suffer most if we do not comply.

The magnitude of the problem is poorly defined. The total number of U. S. citizens in foreign medical schools is unknown but is estimated to be 6,000. Assuming that half of the students have completed the first two years in a foreign medical school and take Part I NBME, the percent that will pass is unknown. It is probably high since passing is based on the average of all subjects and is placed at the 11th percentile. Low scores on several of the seven test subjects are easily raised to a passing average by scores on other subjects.

Another variable which is unknown at this time is the number of U. S. medical schools that will reject capitation funds. Will only schools such as Johns Hopkins, Harvard, Yale, and Stanford be able to stand against this legislation? Assignment will be made to the remaining medical schools which comply with the provisions of the legislation at this point in time. No medical school in this country knows whether it will be assigned 5 or 25 students.

A special factor of concern to Floridians is that more than half of the U. S. citizens in foreign medical schools are from northeastern states. Perhaps HEW will attempt to get residents of a state into medical schools supported by that state but there is no provision for such a mechanism. To do so completely is impossible even theoretically.

Of special concern to the USF College of Medicine is that our three year curriculum provides no entry point for transfer students. Our first academic period begins in July and extends until October of the following year. Introduction to Medicine, Physical Diagnosis, and Introduction to Psychiatry are coordinated with the teaching of the basic sciences rather than being taught after two years devoted largely to basic sciences as is done in the usual four year curriculum. Appropriate modification of our curriculum will be required to assure that the students assigned to us have a reasonable chance of remedying any possible deficiencies. This task must be done without at the same time impairing the quality of education of our regular students.

► Dr. Boren, University of South Florida, Tampa 33612.

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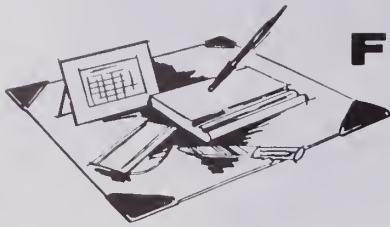


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FROM THE EDITOR'S DESK

RESIDENTS

The California Medical Association has created a component medical society for resident physicians. The new society will have proportionate equal representation with other components in the CMA House of Delegates. About one-third of all state medical associations now have set up a section for resident physicians or are giving it serious consideration.

* * * *

"UNNECESSARY" SURGERY

The issue of "unnecessary surgery" has been revived with a Harvard School of Public Health news conference on a new book entitled *Costs, Risks and Benefits of Surgery*. The authors agreed that to determine adequately the benefit-risk prospects of surgery will require sophisticated methods of communication among physicians and the public over a period of time. One author, Benjamin Barnes, M.D., a Harvard surgeon, said the word "unnecessary" is troublesome because only a small fraction of surgery performed in this country could be labelled as "true abuse."

* * * *

JOHNSTOWN FLOOD

The American Medical Association and Pennsylvania Medical Society are coming to the aid of physicians victimized by the July flooding in Johnstown, Pa. Each is providing \$150,000 for noninterest, guaranteed loans of up to \$7,000 for individuals and \$21,000 for groups of three or more physicians affected by the flood. The loans are to be repaid by July 30, 1982 at a minimum rate of \$150 per month.

* * * *

COMMEMORATIVE STAMPS

AMA has asked the U.S. Postal Service to consider issuing a commemorative stamp honoring Joseph Goldberger, M.D., who is credited with major accomplishments in the fields of nutrition and preventive medicine. The 50th anniversary of his death will occur in 1979. AMA also nominated William Osler, M.D., William Beaumont, M.D., Austin Flint, M.D., William S. Halsted, M.D., and Harvey Cushing, M.D., as other commemorative stamp subjects.

* * * *

PROFESSIONAL ADVERTISING

New York physicians now may advertise their services and fees in newspapers and magazines. The ruling of the New York State Board of Regents became effective on October 1 and applies to all professionals except lawyers and clergy. As for radio and television, doctors may advertise their services, but not fees.

* * * *

DRUG WARNING LABEL

AMA has criticized a proposed warning label for prescription drug packages as being too alarming. A Kennedy-sponsored bill would require the following on drug packages: "The Federal Food, Drug, and Cosmetic and Devices Administration approves this drug or device for the following purposes and no other purpose." An AMA witness told Kennedy's Subcommittee on Health that the statement "raises a spectre that a drug as prescribed is dangerous."

* * * *

MEDICAL EDUCATION

The Liaison Committee on Medical Education has been recognized as the accrediting agency for the nation's medical schools for a two-year period. The U.S. Office of Education extended recognition despite a challenge by the Federal Trade Commission's Bureau of Competition on grounds of potential conflict of interest.

* * * *

TELEVISION VIOLENCE

The nation's three commercial television networks apparently are responding to the current intensified campaign against television violence. According to veteran actor David Janssen, "all three networks are running so scared of the threatened boycott against violence by the AMA and the PTS that they don't know what they're doing next." The AMA has asked ten major corporations to review advertising policies that support TV shows containing prime-time violence. J. Walter Thompson, the country's largest advertising agency, is working with clients to avoid violent programs.

* * * *

PSRO

The AMA says that Professional Standards Review Organizations should not be regarded as a convenient source of information for government agents, researchers or the merely curious. This was contained in an AMA statement to HEW commenting on draft specifications for regulations on confidentiality. One proposed revision would permit PSROs to release information to state and federal licensing bodies or law enforcement agencies. "PSROs should not become investigatory arms of law enforcement bodies nor should they involve themselves in licensing or accreditation functions," the AMA said.

* * * *

AMA-ERF

The American Medical Association Auxiliary has presented more than \$1.5 million to the AMA Education and Research Foundation. The check, presented during the AMA convention in June, was an Auxiliary record for contributions to AMA-ERF.

* * * *

SCREENING

State and Local medical societies have been urged to work with schools to develop methods of referral to physicians so that fragmented, disjointed screening programs can be avoided. At the 1977 AMA Convention, the House of Delegates said mass screenings of school children, should be undertaken only with the approval of the local medical society. Periodic evaluation of the child as a whole should be done by the child's physician, the House said.

* * * *

SUPREME COURT

The U.S. Supreme Court ruled that advertising of fees for routine legal services cannot constitutionally be prohibited. The ruling struck down a disciplinary rule of the Arizona Supreme Court which had barred advertising by lawyers in newspaper and other media. However, the highest court made it clear the ruling applied only to a brief factual statement of fees charged for specific, routine services.

* * * *

PHYSICIANS DROPPED

HEW Secretary Califano has dropped four members of the 11-member National Professional Standards Review Organization Council two years before their terms ended. Califano explained he wanted to stagger terms of appointees. All four of the dropped members are physicians, leaving practicing physicians in the minority among the remaining members.

* * * *

DEFENSIVE MEDICINE

According to an AMA poll, three out of every four physicians are trying to protect themselves from potential lawsuits by practicing "defensive medicine." A large number of physicians say they are ordering one or two more tests and some are ordering three or four.

* * * *

The Editor



ADMINISTRATOR-FMA
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Final classification of the less-than-effective indications requires further investigation.

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Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

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Clinical Evaluation of the Immunologically Involved Patient

Part II

Morton L. Hammond, M.D.

Abstract: The first part of this series, published in the September issue of the Journal of the Florida Medical Association, presented background information related to the development of cells that participate in the immune response (T, B, and phagocytic), mediators that are generated to effect the immune response (immunoglobulins, T cell mediators, complement), and their function. A classification of immune disorders and laboratory procedures useful in diagnosis was presented.

In this section, the clinical approach is detailed with reference to the history and laboratory data required to establish the diagnosis of deficiency states, phagocytic or complement aberration, disorders of class 1-4, etc. Finally there is a check list of disorders, cross referenced with laboratory procedures that could serve as a guide to the study of these states.

General Evaluation and Laboratory Data Approach to Patient Care

Some of the areas of illness that should suggest the need for immunologic consideration follow.

Since the major function of the immune system is protection against infection, any patient with recurrent or chronic, resistant or disseminated infection should be considered from the point of view of immune competence. Patients with chronic diarrhea, inability to thrive, and wasting are likewise suspects. Patients with atopic disease are overt candidates for consideration. Those with disorders of joints, thyroid, skin and other structures

associated with autoimmune disease should be studied immunologically. Other conditions such as susceptibility to virus and fungus infection, extensive and acute development of warts,⁶⁵ etc., should dictate the need for immunologic evaluation.

Certain of the immunoglobulin dysfunctions give rise to specific syndromes and disorders. As an example, there can be a variety of deficiency and functional diseases. A deficiency of IgG can be associated occasionally with a sprue-like syndrome and ataxia telangiectasia. IgE has been associated with atopic disorders such as asthma, nasal allergy and urticaria. The level of IgE is particularly high in eczematous conditions.

History

In patients with possible immunologic defects, a good medical history is essential, and there should be in addition particular attention paid to the data which frequently are not included in otherwise complete reports.

History should include family history of infection, of allergy or collagen disease, of malignancy as a cause of early death in any member, and other stigmata of immunologic disease, because of the implication of congenital relationships in these disorders. The age of onset is of consequence in that deficiency states appear in infants and B cell problems are often somewhat delayed. There should be a history of dates and types of prior immunizations for the purpose of assaying immunity if any residual immune level is found. Awareness of prior surgery or radiation therapy of the nasopharynx is of consequence. Adenoidectomy, for instance, in a young adult or thymic or adenoid radiation in children color evaluation of the immunologic state. Previous

Dr. Hammond is Chief, Division of Allergy, Jackson Memorial Hospital and Clinical Professor of Medicine, Department of Medicine, University of Miami School of Medicine, Miami.

surgical slides may have lymph nodes whose structure would give insight into the immune state. History of infections and the nature of organisms involved is important and would suggest whether B or T cell is involved. History of previous treatment efforts including use of gammaglobulin is important in evaluating current conditions in allergic or potentially allergic people. An occupational history and environmental history can often give direction to the investigation as in allergic pneumonitis, etc. The usual medical history should include a statement as to the actual time of onset of minimal symptoms rather than the time the symptoms became prominent enough to concern the patient. Data as to frequency, duration, and intensity of various symptoms should be specifically noted. Seasonal aspects of the complaint, change with change of location, known aggravants with particular reference to foods and inhalants, response to antiallergic medications, all are pertinent to an adequate history.

Physical examination should be thorough. Findings will depend upon the condition and may range from the butterfly rash of lupus erythematosus to the purpura of hemolytic disease. Generalized wasting, and manifestations of recurrent infection, and anemia are among the common symptoms or signs that are elicited.

In patients where the history suggests immunologic problems, confirmation must be generally a laboratory function.

General Laboratory Data

First the CBC should be considered with more than usual attention. Frequently if the white blood count is normal, a differential is not done, and this practice should be discouraged. It is important that absolute neutrophil and lymphocyte counts are available. Lymphocyte levels under 1500 and poly levels under 1800 are clinically significant. Immature cells on the smear give some implication as to the blast activity going on.

Eosinophilia, inclusion bodies in the white blood cells, abnormalities of red cell morphology, and sedimentation rate are pertinent to diagnosis of immunologic disorders.

A sweat test is an easily acquired study, important in chronic or recurrent sinopulmonary infection or diarrhea. If x-rays are not already available, one should have lateral films of the chest (for thymic shadow) and of the skull (to evaluate adenoid tissue). Hyperplastic or absent adenoid or thymic shadows may be demonstrated with obvious implication particularly in infants.

As part of an initial screening test, quantitative immunoglobulins, isohemagglutinins and skin tests for PPD and monilia, trichophyton, as well as complement levels should be taken. At this point one should be able to type the disorder in question as to T cell, B cell, etc. The following pages detail that evaluation.

Laboratory Data Appropriate to the Particular Disorder

Such data are directed at evaluating phagocytic function, humoral immunity, cellular immune capability and complement function.

Deficiency Disease States

Whenever the physician encounters recurrent infection, he must suspect, among other things, deficiency or dysfunction of the phagocytic system and/or complement. Tests of phagocytic function are affected by many variables such as the presence and activity of complement, PH, and electrolytes present in the environment, presence or absence of calcium or magnesium and other factors. Activity of these cells can be estimated, however, by exposing them to a standardized suspension of ingestible particles and counting the percentage of cells that engulf particles.

The average number of particles in cells then can be expressed as the avidity index. The product obtained by multiplying these indices is the number of particles ingested per cell.⁶⁶

The nitro blue tetrazolium (NBT) test is a method of screening the function of the hexose monophosphate system. A colorless dye (NBT) is added to a suspension of cells, and when the hexose monophosphate system is active (as in phagocytosis) the reduction of NBT is recognized by a color change to blue. In recent studies, the value of this test has been questioned and, at this time, it is not considered any more reliable than conventional hematology for determination of infection.⁶⁷ However, it is useful in diagnosis of chronic granulomatous disease and similar situations where cell function is in question.⁶⁸

Another test directed at evaluation of phagocytes is called the Rebuck skin window. This is done by abrading the skin slightly, applying a drop of saline or allergen, and covering with a slip held in place by tape for four to five hours. The slide is then removed, new challenge material applied, and a new slide is held in place for 24 hours more. Slides are stained and leukocytes are evaluated. In the four

hour slide, 90% of cells should be polys. In 24 hours, more than 50% should be active macrophages or monocytes (somewhat more macrophages than monocytes). Cell clumps should be seen in such a preparation. These clumps may be made up of basophils and eosinophils. In deficiency states the activated macrophages are fewer in number, and cell clumps are not plentiful.⁶⁹

Complement

Complement can be studied by CH 50 screen or specific quantitative evaluations of particular factors.²⁵

B Cell Deficiency

In situations where one has a patient with recurrent infection, eczema, failure to thrive and other hallmarks pointed out previously, it is incumbent on the physician to consider humoral B cell deficiency. Tests should include: (1) Test for the various immunoglobulins (IgG, IgA, IgM) utilizing the Mancini radial diffusion technique or radioimmunoassays. Note that one can have a normal IgG level but still have deficiency disease because the effective subtype is absent and in such instances quantitation of IgG subtypes is necessary. (2) Test for a specific level of existing antibodies should be done. As an example, the absence of isohemagglutinin titers to natural A and B isohemagglutinins is evidence of IgM deficiency since this immunoglobulin type exercises this particular function. (3) Test for specific antibody response to the Schick test. Previous immunization to Schick (diphtheria) antigen should give immunity to diphtheria and hence a negative Schick test.* If the test remains positive, this is an indication of IgG deficiency. (4) Test to determine presence or absence of antibody producing cells by biopsy. An appropriate site for biopsy is the rectal mucosa. Immunofluorescent studies of the tissue can demonstrate presence or absence of the various immunoglobulins. (5) The morphologic nature of the lymph nodes particularly after stimulation with an antigen such as tetanus toxoid peripherally in the same extremity should be helpful. Absence of plasma cells and of cells in the germinal centers would suggest B cells defects. (6) Test of circulating lymphocytes for surface immunoglobulins with immunofluorescent techniques.

T Cell Deficiency

Should the patient be subject to repeated viral or fungal infections, failure to thrive, or general debility, one should test for cellular (T cell type) deficiency syndromes. Such test should include: (1) CBC and differential as noted previously. (2) X-ray of head and chest for thymic or adenoid shadow. (3) In vivo skin tests including the battery of delayed reacting antigens (monilia, SK-SD, mumps, histoplasmosis, tetanus toxoid, PPD), DNCB test if necessary, and lymph node biopsy (which may show paracortical depletion of cells). (4) In vitro tests including rosette, MIF, lymphocyte transformation.

Disease States Involving Aberration of Function

Type I Disorders

Should the patient be involved with cough, wheeze, shortness of breath, recurrent colds, sinus infections, headaches, ear involvement, skin manifestations, gastrointestinal complaints, drenching sweats, urticaria, eczema, or any combination, it is necessary to consider IgE mediated or allergic disorders. (Type I Gell and Coombs). Tests of value would include CBC for specific reference to eosinophil level, smears of secretions again for eosinophil levels, skin or RAST tests for specifically sensitive IgE antibody and IgE blood levels. In some highly sensitive patients where anaphylaxis is feared, such as in bee sensitive patients, it may be wise to do RAST test or the specific leukocyte histamine release tests where white cells on exposure to antigens release histamine.

The diagnosis of allergy, however, depends primarily on history. The various criteria that must weigh in the diagnosis are family history, (particularly parental), presence of several stigmata of allergy involving separate systems (such as chest and skin), active favorable response to antiallergic medications (such as antihistamines), demonstration of the patterns of allergic disease (such as known food or inhalant allergies, seasonal history, etc.) and, finally, presence of physical laboratory corroboration (symptoms, signs, eosinophil levels, etc.). Any or several of the criteria may be absent and yet clear allergic diagnoses can be established.

Type II Disorders

Should the patient have problems related to transfusion reactions, systemic lupus erythematosus, etc., the physician would be dealing with a type II disorder. Two general subtypes of reaction can be

*Schick reagent may be acquired from Texas State Department of Health, Austin.

detected in this category. In the one, antibody is directed against the cell membrane of various tissues in the patient. In this group are the transfusion reactions, autoimmune hemolytic anemia, hemolytic disease of the newborn, and systemic lupus (in association with complex type III reactor), post-streptococcal glomerulonephritis, etc. The second type is affected by exogenous materials which become fixed to tissue and the complex, haptenic or otherwise, is the antigenic determinant. Goodpasture's syndrome, chronic glomerulonephritis and insulin resistance belong in this group. This is characterized by the drug reactions. Studies related to this category of disease should include those usually medically and immunologically oriented including immunofluorescences and/or peroxidase labeled antibody, Coombs antiglobulin, complement fixation, and latex particle agglutination.

Immunofluorescences can demonstrate autoimmune antibodies in serum or tissue. The antinuclear antibody (ANA), antithyroid, antiparietal cell, anti-muscle, antimitochondrial, etc., can be demonstrated depending on the condition under study.

Type III Disorders

Should the patient have immune complex (Type III Gell and Coombs) involvement, the listing of symptoms that could point to it would be so all encompassing as to be meaningless. Since the pathology is largely related to the serendipitous deposit of complexes in tissue not specifically involved in the antigen-antibody union, certain organ systems are more prominently involved. Therefore, patients with conditions involving nephritis should have immunologic consideration. This also applies to such disease states as vasculitis, periarteritis, joint involvement, chronic skin symptoms, pleural or peritoneal effusions or inflammation, chronic liver disease, chronic and recurrent pulmonary infiltrates, multisystem disease disorders, certain specific syndromes such as Raynaud's or Sjogren's, hematologic states such as purpura and anemias, and in specific illnesses such as serum sickness, lupus erythematosus, and rheumatoid arthritis. In the evaluation of such patients aside from the medically oriented laboratory data (CBC, urinalysis, blood profiles, sedimentation rate, etc.), the following immunologically oriented studies should be applicable. Quantitative serum protein immunoglobulin levels and immunoelectrophoresis should be done. Immune complex disease can be suspected if there should be demonstrated a phenomena described as "trailing" from the antigen well. This is a diffuse

oblong spot that trails out toward the cathode. There usually is also an abnormal crescent-shaped precipitin arc as well.⁷⁰ This is not in itself diagnostic, however. Serum complement levels, rheumatoid factor, ANA, Coombs test, and finally biopsy of tissue for immunofluorescence studies would be appropriate.

Type IV Disorders

In type IV disorders, the integrity of the T cell system is in question. Clinical situations where investigation of T cell function may be pertinent is in anergic states, postoperative malignancy, deficiency syndromes, drug reactions, a variety of autoimmune disorders, etc. In addition to the basic laboratory data, use of the battery of delayed skin test antigens are applicable. The *in vitro* tests, MIF, rosette, and lymphocyte transformation, are also recommended.

Scores of laboratory procedures have not been mentioned. Either they are not directly related to immunologic disease such as the heterophile agglutination or they have limited use in specific disorders such as cold agglutinins (in primary atypical pneumonia or acquired hemolytic anemia), anti-mitochondrial antibody (in chronic biliary cirrhosis), antismooth muscle antibody (in chronic active hepatitis), and others.

The following classification from Roitt (table 3)³³ supplements Table 2 to fill this gap in part, and Table 4 may give specific direction to investigation.

I have constructed an additional table that will serve as a guide to laboratory investigation (Table 4). It should be noted that the studies indicated need not necessarily be applied in all cases of a given disease. Furthermore, it does not include some tests that are rarely applicable; as in the case of transfusion reactions and hemolytic disorders the variety of tests and circumstances are so numerous and complex that inclusion would be undesirable in such a guide. Those tests underlined are most commonly obtained. As an example, in Group I urticaria, one may or may not choose to skin test in that such testing has been questioned as to its validity in this circumstance. Furthermore, one would not do both a skin test and RAST test in that these tests both reflect the same data, i.e. IgE level.

In addition, complement levels would not likely be productive in acute recurrent urticaria, but rather in chronic disorders.⁷²

Table 3.—Autoantibodies in Human Disease.
(IFT-immunofluorescent test; CFT-complement fixation test)

Disease	Antigen	Detection of antibody
Hashimoto's thyroiditis	Thyroglobulin	Precipitins; passive haemaggln. IFT on fixed thyroid
Primary myxedema	2nd Colloid Ag (CA2)	IFT on fixed thyroid
	Cytoplasmic microsomes	IFT on unfixed thyroid; with thyroid microsomes
	Cell surface	IFT on viable thyroid cells; C'-mediated cytotoxicity
Thyrotoxicosis	Probably cell surface	Bioassay-stimulation of mouse thyroid in vivo
Sympathetic ophthalmia	Uvea	(Delayed skin reaction to uveal extract)
Myasthenia gravis	Skeletal and heart muscle; thymus myoid cells	IFT on skeletal muscle
Autoimmune haemolytic	Erythrocytes	Coombs' antiglobulin test
Idiopathic thrombocytopenic purpura	Platelets	Shortened platelet survival in vivo
Primary biliary cirrhosis	Mitochondria (mainly)	IFT on mitochondria rich cells (e.g. distal tubules of kidney); CFT kidney
Active chronic hepatitis	Smooth muscle, nuclei (mainly)	IFT (e.g. on gastric mucosa)
Ulcerative colitis	Colon 'lipopolysaccharide'	IFT; passive haemaggln. (cytotoxic action of lymphocytes on colon cells)
Sjogren's syndrome ¹⁰	Ducts, mitochondria, nuclei, thyroid, altered IgG	IFT; antiglobulin tests
Rheumatoid arthritis ⁴⁸	Altered IgG	Antiglobulin tests: latex aggln. and sheep red cell aggln. test (SCAT)
Discoid lupus erythematosus	Nuclear	IFT
Dermatomyositis	Altered IgG	Antiglobulin tests
Scleroderma ⁷¹	DNA	Pptn.; CFT; IFT
Systemic lupus erythematosus	Nucleoprotein Cytoplasmic sol. ag Array of other ag. incl. formed elements of blood, clotting factors, altered IgG and Wasserman antigen	IFT; latex aggln. L.E. cells 'Non-organ sp. CFT'
		'Biological false positive' CFT

Other tests referred to under urticaria may sometimes be indicated particularly when one considers the condition to be a manifestation of another disorder. For instance, biopsy may be indicated in some persistent urticarial lesions since vasculitis has been implicated in some patients.

All of this is predicated on the understanding that an adequate basic investigation has already been undertaken, i.e. stool examination for ova and parasites, dental and general surveys for foci of infection, CBC, sweat tests in sinorespiratory disease, and diarrhea, etc.

It is with this understanding that the testing protocol is presented.

Table 4.—Allergic and Immunologic Disorders and Tests Which May Be Appropriate in Investigation.

Note: Underlined numbers indicate more important Test. Code to numbers included as part of "Major Special Tests Useful in Diagnosis of Allergic and Immunologic Disorders."

TYPE I DISORDERS

Asthma: 22, 26, 31, 32, 40, 41, 43, 45

Allergic Bronchitis:

Allergic Rhinitis: 31, 32, 40, 41, 45

Allergic Sinusitis:

Urticaria: 9, 19, 27, 28, 31, 32, 38, 41, 43, 44

Angioedema: 14, 28, 31, 32, 41, 43

Other Atopic Diseases: 31, 32, 40, 41, 43

GROUP II DISORDERS

Autoimmune Hemolytic Disorders: 4, 8, 9, 10, 11, 19, 28, 30, 32

Transfusion Reactions:

Autoimmune Thyroiditis: 4, 9, 10, 11, 14, 17

Goodpasture's Disease: 9, 14, 25, 28, 37, 38, 39

Drug Reactions: 7, 8, 10, 11, 14, 21, 32, 35, 41

Pernicious Anemia: 14, 16, 40

Myasthenia Gravis: 4, 14, 24, 40

Pemphigus: 4, 14, 17, 38

Ulcerative Colitis: 4, 14, 24, 32

GROUP III DISORDERS

Serum Sickness: 9, 14, 21, 23

Poststreptococcal Nephritis: 9, 14, 17, 23, 38

Postviral Nephritis:

Rheumatoid Arthritis: 4, 9, 17, 18, 21, 27, 28, 40

Lupus Erythematosus: 1, 4, 17, 19, 24, 27, 28

Polyarteritis: 4, 9, 14, 23, 24, 28, 38

Hypersensitivity Pneumonia: 14, 21, 38

Active Chronic Hepatitis: 2, 9, 14, 28, 38

GROUP IV DISORDERS

Tuberculosis with Cavitation: 36

Graft Rejection Others:

Tumors (Malignant): 3, 9, 29, 36, 37

Contact Dermatitis: 14, 33, 38

Sjogren's: 4, 9, 14, 17, 24, 38

Hodgkin's Disease: 1, 17, 23, 24, 34, 37

Sarcoid: 4, 9, 23, 14, 36, 37, 38

DEFICIENCY DISEASES

For B cell Disorders: 15, 24, 29, 36, 37

Swiss, — Bruton, etc.

For T cell Disorders: 6, 7, 15, 34, 36, 37

Swiss, — DiGeorge, etc.

Chronic Granulomatous Disease: 5, 6, 7, 24, 25, 23, 34, 35, 36, 38

PROLIFERATIVE DISORDERS

Myeloma: 13, 23, 24

Waldenstrom: 13, 20, 23, 24

Heavy Chain: 13, 24

Light Chain:

Major Special Tests Useful in Diagnosis of Allergic and Immunologic Disorders

SEROLOGY

1. VDRL
2. HAA (hepatitis assoc. antigen)
3. CEA (cytoembryonic antigen)
4. ANA
5. NBT
6. MIF
7. Blast transformation
8. Coombs (direct or indirect)
9. Complement fixation

10. Precipitin test
11. Agglutination test
12. Isohemagglutinin Test
13. RIA
14. Immunofluorescent test (see chart)
15. Rosette test
16. Competitive binding test
17. Rheumatoid factor
18. C-Reactive protein
19. Cryoglobulin
20. SIA test
21. Specific antibody titre (immunodiffusion)
22. Secretion assay for IgA, IgM
23. Serum electrophoresis
24. Immunoelectrophoresis
25. Peroxidase reduction test
26. Alpha-1- antitrypsin assay
27. Latex or bentonite particle agglutination
28. Complement Assay (C1 esterase inhibitor C3-C4-CH50)
29. Quantitative immunoglobulins
30. Cold and warm agglutinins

SKIN TEST

31. Skin test
32. RAST test
33. Patch test
34. DNCB
35. Rebuck skin window
36. Specific bacterial or mycotic skin test

PATHOLOGY

37. Node biopsy
38. Tissue biopsy
39. Mucosal (rectal) biopsy

OTHERS

40. Medication response
41. Histamine release
42. Phagocytic index
43. Challenges with histamine or metacholine
44. Stools for ova and parasites
45. Sweat test

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6. Nephropexy
7. Circumcision, Female
8. Hysterotomy
9. Supracervical Hysterectomy
10. Uterine Suspension
11. Uterine Suspension with Presacral Sympathectomy
12. Hypogastric or Presacral Neurectomy
13. Fascia Lata by Stripper — when used to treat lower back pain
14. Fascia Lata by Incision — when used to treat lower back pain
15. Ligation of Femoral Vein, Unilateral and Bilateral — when used to treat Post Phlebitic Syndrome
16. Excision of Carotid Body Tumor — when used to treat Asthma
17. Sympathectomy, Thoracolumbar, Unilateral or Bilateral — when used to treat Hypertension
18. Sympathectomy, Lumbar — when used to treat Hypertension
19. Basal Metabolic Rate — BMR
20. Protein Bound Iodine — PBI
21. Icterus Index
22. Ballistocardiogram — BCG
23. Phonocardiogram with Interpretation and Report
24. Angiocardiology, using Carbon Dioxide, Supervision and Interpretation Only
25. Angiocardiology, Single Plane, Supervision and Interpretation Only, in Conjunction with Cineradiography
26. Angiocardiology, Multi-Plane, Supervision and Interpretation Only, in Conjunction with Cineradiography
27. Angiography — Coronary, Unilateral, Selective Injection, Supervision and Interpretation Only, Single View unless in an Emergency
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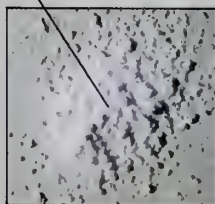


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It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.



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Pediatric Hypercholesterolemia	0.05 mg./kg. body weight	0.05 mg./kg.	0.1 mg./kg. body weight	4.0 mg.
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Description

CHOLOXIN (sodium dextrothyroxine) is the sodium salt of the dextrothyroxine isomer of thyroxine. It is chemically described as D-3,5,3',5'-tetraiodothyronine sodium salt.

Actions

The predominant effect of CHOLOXIN (sodium dextrothyroxine) is the reduction of serum cholesterol levels in hyperlipidemic patients. Beta lipoprotein and triglyceride fractions may also be reduced from previously elevated levels.

Most of the available evidence indicates that CHOLOXIN (sodium dextrothyroxine) stimulates the liver to increase catabolism and excretion of cholesterol and its degradation products via the biliary route into the feces. Cholesterol synthesis is not inhibited and abnormal metabolic end-products do not accumulate in the blood.

Indications

This is not an innocuous drug. Strict attention should be paid to the indications and contraindications.

CHOLOXIN (sodium dextrothyroxine) is an antilipidemic agent used as an adjunct to diet and other measures for the reduction of elevated serum cholesterol (low density lipoproteins) in euthyroid patients with no known evidence of organic heart disease.

The drug is also indicated in the treatment of hypothyroidism in patients with cardiac disease who cannot tolerate other types of thyroid medication. Before prescribing, note the following: Results from a randomized clinical study have indicated a possible adverse effect when CHOLOXIN (sodium dextrothyroxine) is administered to a patient receiving a digitalis preparation. There may be an additive effect. This additive effect may possibly stimulate the myocardium excessively, in patients with significant myocardial impairment. CHOLOXIN (sodium dextrothyroxine) dosage should not exceed 4 mg per day when the patient is receiving a digitalis preparation concomitantly. Careful monitoring of the total effect of both drugs is important.

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Contraindications

The administration of CHOLOXIN (sodium dextrothyroxine) to euthyroid patients with one or more of the following conditions is contraindicated:

1. Known organic heart disease, including angina pectoris; history of myocardial infarction; cardiac arrhythmia or tachycardia, either active or in patients with demonstrated propensity for arrhythmias; rheumatic heart disease; history of congestive heart failure; and decompensated or borderline compensated cardiac status.
2. Hypertensive states (other than mild, labile systolic hypertension).
3. Advanced liver or kidney disease.
4. Pregnancy.

5. Nursing mothers.

6. History of iodism.

Warnings

CHOLOXIN (sodium dextrothyroxine) may potentiate the effects of anticoagulants on prothrombin time. Reductions of anticoagulant dosage by as much as 30% have been required in some patients. Consequently, the dosage of anticoagulants should be reduced by one-third upon initiation of CHOLOXIN therapy and the dosage subsequently readjusted on the basis of prothrombin time. The prothrombin time of patients receiving anticoagulant therapy concomitantly with CHOLOXIN therapy should be observed as frequently as necessary, but at least weekly, during the first few weeks of treatment.

In the surgical patient, it is wise to consider withdrawal of the drug two weeks prior to surgery if the use of anticoagulants during surgery is contemplated.

When CHOLOXIN (sodium dextrothyroxine) is used as thyroid replacement therapy in hypothyroid patients with concomitant coronary artery disease (especially those with a history of angina pectoris or myocardial infarction) or other cardiac disease, treatment should be initiated with care. Special consideration of the dosage schedule of CHOLOXIN (sodium dextrothyroxine) is required. This drug may increase the oxygen requirements of the myocardium, especially at high dosage levels. Treated subjects with coronary artery disease must be seen at frequent intervals. If aggravation of angina or increased myocardial ischemia, cardiac failure, or clinically significant arrhythmia develops during the treatment of hypothyroid patients, the dosage should be reduced or the drug discontinued.

Special consideration must be given to the dosage of other thyroid medications used concomitantly with CHOLOXIN (sodium dextrothyroxine). As with all thyroactive drugs, hypothyroid patients are more sensitive to a given dose of CHOLOXIN (sodium dextrothyroxine) than euthyroid patients.

Epinephrine injection in patients with coronary artery disease may precipitate an episode of coronary insufficiency. This condition may be enhanced in patients receiving thyroid analogues. These phenomena should be kept in mind when catecholamine injections are required in sodium dextrothyroxine-treated patients with coronary artery disease.

Since the possibility of precipitating cardiac arrhythmias during surgery may be greater in patients treated with thyroid hormones, it may be wise to discontinue CHOLOXIN (sodium dextrothyroxine) in euthyroid patients at least two weeks prior to an elective operation. During emergency surgery in euthyroid patients, and in surgery in hypothyroid patients in whom it may not be advisable or possible to withdraw therapy, the patients should be carefully observed.

There are reports that sodium dextrothyroxine in diabetic patients is capable of increasing blood sugar levels with a resultant increase in requirements of insulin or oral hypoglycemic agents. Special attention should be paid to parameters necessary for good control of the diabetic state in dextrothyroxine-treated subjects and to dosage requirements of insulin or other antidiabetic drugs. If sodium dextrothyroxine is later withdrawn from

patients who had required an increase of insulin (or oral hypoglycemic agents) dosage during its administration, the dosage of antidiabetic drugs should be reduced and adjusted to maintain good control of the diabetic state.

When either or both impaired liver or kidney function are present, the advantages of CHOLOXIN (sodium dextrothyroxine) therapy must be weighed against the possibility of deleterious results.

Use in Women of Childbearing Age

Women of childbearing age with familial hypercholesterolemia or hyperlipemia should not be deprived of the use of this drug; it can be given to those patients exercising strict birth control procedures. Since pregnancy may occur despite the use of birth control procedures, administration of CHOLOXIN (sodium dextrothyroxine) to women of this age group should be undertaken only after weighing the possible risk to the fetus against the possible benefits to the mother. Teratogenic studies in two animal species have resulted in no abnormalities in the offspring.

Precautions

It is expected that patients on dextrothyroxine therapy will show greatly increased serum protein-bound-iodine levels. These increased serum PBI values are evidence of absorption and transport of the drug, and should NOT be interpreted as evidence of hypermetabolism; similarly, they may not be used for titrating the effective dose of CHOLOXIN (sodium dextrothyroxine). PBI values in the range of 10 to 25 mcg% in treated patients are common.

If signs or symptoms of iodism develop during CHOLOXIN (sodium dextrothyroxine) therapy, the drug should be discontinued.

A few children with familial hypercholesterolemia have been treated with CHOLOXIN for periods of one year or longer with no adverse effects on growth. However, it is recommended that the drug be continued in patients in this age group only if a significant serum cholesterol-lowering effect is observed.

Adverse Reactions

The side effects attributed to dextrothyroxine therapy are, for the most part, due to increased metabolism, and may be minimized by following the recommended dosage schedule. Adverse effects are least commonly seen in euthyroid patients with no signs or symptoms of organic heart disease; the incidence of adverse effects is increased in hypothyroid patients, and is highest in those patients with organic heart disease superimposed on the hypothyroid state.

In the absence of known organic heart disease, some cardiac changes may be precipitated during sodium dextrothyroxine therapy. In addition to angina pectoris, arrhythmia consisting of extrasystoles, ectopic beats, or supraventricular tachycardia, ECG evidence of ischemic myocardial changes and increase in heart size have been observed. Myocardial infarctions, both fatal and non-fatal, have occurred, but these are not unexpected in untreated patients in the age groups studied. It is not known whether any of these infarcts were drug related.

Changes in clinical status that may be related to the metabolic action of the drug include the development of insomnia, nervousness, palpitations, tremors, loss of weight, lid lag, sweating, flushing, hyperthermia, hair loss, diuresis, and menstrual irregularities. Gas-

trointestinal complaints during therapy have included dyspepsia, nausea and vomiting, constipation, diarrhea, and decrease in appetite.

Other side effects reported to be associated with CHOLOXIN (sodium dextrothyroxine) therapy include the development of headache, changes in libido (increase or decrease), hoarseness, tinnitus, dizziness, peripheral edema, malaise, tiredness, visual disturbances, psychic changes, paresthesia, muscle pain, and various bizarre subjective complaints. Skin rashes, including a few which appeared to be due to iodism, and itching have been attributed to dextrothyroxine by some investigators. Gallstones have been discovered in occasional dextrothyroxine-treated patients and cholestatic jaundice has occurred in one patient, although its relationship to CHOLOXIN therapy was not established.

In several instances, the previously existing conditions of the patient appeared to continue or progress during the administration of CHOLOXIN (sodium dextrothyroxine); a worsening of peripheral vascular disease, sensorium, exophthalmos, and retinopathy have been reported.

CHOLOXIN (sodium dextrothyroxine) potentiates the effects of anticoagulants, such as warfarin or Dicumarol, on prothrombin time, thus indicating a decrease in the dosage requirements of the anticoagulants. On the other hand, dosage requirements of antidiabetic drugs have been reported to be increased during dextrothyroxine therapy (see WARNINGS section).

Dosage and Administration

For adult euthyroid hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is 4 to 8 mg per day. The initial daily dose should be 1 to 2 mg to be increased in 1 to 2 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, if that dosage level is indicated to effect the desired lowering of serum cholesterol.

When used as partial or complete substitution therapy for levothyroxine in hypothyroid patients with cardiac disease who cannot tolerate other types of thyroid medication, the initial daily dose should be 1 mg to be increased in 1 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, preferably the lower dosage. The maximum in patients receiving digitalis therapy is 4 mg.

For pediatric hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is approximately 0.1 mg (100 mcg) per kilogram. The initial daily dosage should be approximately 0.05 mg (50 mcg) per kilogram to be increased in up to 0.05 mg (50 mcg) per kilogram increments at monthly intervals. The recommended maximal dose is 4 mg daily, if that dosage is indicated to effect the desired lowering of serum cholesterol.

If new signs or symptoms of cardiac disease develop during the treatment period, the drug should be withdrawn.

How Supplied

CHOLOXIN (sodium dextrothyroxine) is supplied in prescription packages of scored 1, 2, 4, and 6 mg tablets.

SPECIAL ARTICLES

A Victory for Laetrile

In the winter and spring of 1977, promoters of the supposed anti-cancer agent, Laetrile, succeeded in several states, in getting laws passed relating to its use. Their success extended into Florida, where the following law was passed last spring.

CHAPTER 77-30

Committee Substitute for House Bill No. 768

AN ACT relating to prescription and administration of laetrile; prohibiting hospitals and health facilities from interfering with the physician-patient relationship by restricting use of amygdalin (laetrile); providing conditions; providing for written release; providing for disclosure by the physician; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. No hospital or health facility shall interfere with the physician-patient relationship by restricting or forbidding the use of amygdalin (laetrile) when prescribed or administered by a physician licensed under chapter 458 or 459, Florida Statutes, and requested by a patient unless the substance as prescribed or administered by the physician is found to be harmful by the State Boards of Medical Examiners and Osteopathic Medical Examiners in a hearing conducted under the provisions of the Administrative Procedure Act, chapter 120, Florida Statutes. Furthermore, no hospital or health facility shall remove the staff privileges of a physician solely because said physician prescribed or administered amygdalin (laetrile) to a patient under the conditions set forth in this act.

Section 2. No physician licensed under

chapter 458 or 459, Florida Statutes, shall be subject to disciplinary action by the State Boards of Medical Examiners and Osteopathic Medical Examiners for prescribing or administering amygdalin (laetrile) to a patient under his care who has requested the substance unless the State Boards of Medical Examiners and Osteopathic Medical Examiners, in a hearing conducted under the provisions of the Administrative Procedure Act, chapter 120, Florida Statutes, has made a formal finding that the substance is harmful.

Section 3. The patient, after being fully informed as to alternative methods of treatment and their potential for cure and upon request for the administration of amygdalin (laetrile) by his physician, shall sign a written release, releasing the physician and, when applicable, the hospital or health facility from any liability therefor.

Section 4. The physician shall inform the patient in writing that amygdalin (laetrile) has not been approved as a treatment or cure by the Food and Drug Administration of the United States Department of Health, Education and Welfare.

Section 5. This act shall take effect October 1, 1977.

Approved by the Governor May 13, 1977.

Filed in Office Secretary of State May 13, 1977.

Editor's Note: In a very tense, highly charged atmosphere from which reason had fled, before national television cameras, in a committee room of the House of Representatives of the State of Florida filled with emotionally directed supporters of Laetrile, confronted with certain defeat by a unanimous phalanx of the other eleven committee members against his point of view as this bill was "steam-rolled" through the legislative process, Dr. Richard Hodes, in one of his finest moments during the session, made this statement. It eloquently expressed the viewpoint of most members of our profession.

DR. HODES FINAL STATEMENT ON THE LAETRILE BILL IN HOUSE HEALTH AND REHABILITATIVE SERVICES COMMITTEE MEETING ON MAY 21, 1977:

Madame Chairperson, members of the Committee, just a moment in opposition to the bill.

There are people who have come to Tallahassee this week who are victims of cancer and have also been treated with laetrile. They have come to the Capitol convinced, and happily so, that they have been improved and many of them have. At least one person I have seen walking these halls in the last several days has a medical history I happen to know. He has passed up the opportunity for curative surgery and still has cancer. However, that individual I'm convinced would not have been here if he was not convinced that he had been cured.

Now, it is not my intent ever to remove hope from a cancer victim, and I hope that all of our present cancer victims who are taking laetrile have full, complete and happy recoveries. I feel that everyone who has cancer that cannot be treated by any other means or is being treated by other means will have an opportunity to have laetrile if they feel it will help them and a doctor concurs. But frankly, ladies and gentlemen and members of the Committee, this bill really has no real affect on what is going to happen in Florida. All the bill does is say that we cannot prosecute the doctor. We can't take away his license, or remove him from a medical staff simply because he administers laetrile. I submit to you that today in Florida, laetrile is being

administered to patients by physicians. In the many years of laetrile history no physician in Florida has ever been prosecuted or lost his license because he administered laetrile to a patient when that patient has been properly diagnosed and that patient has not been advised to avoid conventional forms of therapy.

Now, cancer is a terrible disease, its treatment requires agonizing decisions by family and by patients, and I have one prayer here this morning. I pray that I, Dr. Temple, and Dr. McDonald are wrong. Because if we're wrong then we are about to intuitively somehow identify a miracle. But if the proponents of this bill are wrong, then members of the Committee, on our consciences as legislators will rest, — because of our stamp of approval, — the lives of thousands. Those present and future victims of cancer who will be lured away by the enticement of laetrile from conventional cures for treatable cancer will be our burden.

I personally, probably in the minority, am going to vote no. I feel in spite of some of the safe guards we have put into this bill that my conscience will be clear. But the conscience of the Florida Legislature is going to have to wrestle with this problem. I hope that what we are deciding to do is correct and I also hope that I am wrong, because that is the only way that all of our consciences can survive the lives of thousands.

Dr. Richard S. Hodes is a member of the Florida House of Representatives, District 68, Hillsborough County, and also Treasurer of the Florida Medical Association.

FDA contends that it would be contrary to the public interest to exempt Laetrile, as some propose, from the efficacy requirements of Federal law (the Kefauver-Harris Amendments). Such an exemption would set an unacceptable precedent for other unproven drugs.

Editor's Note: Dr. Willard E. Manry Jr., of Lake Wales, is in the practice of General Surgery and Family Practice. He sent us this letter expressing his feelings regarding the use of Laetrile in terminally ill cancer patients.

Dear Mrs. _____:

I must tell you that I don't feel any confidence that Laetrile will do your husband any good. Good, however, comes in all sizes, and this appears to be the salient fact that is unacceptable to the FDA and the other opponents of the use of Laetrile. FDA and others persist in terminology referring only to cure.

The only occasion on which I have participated in Laetrile therapy was a lady who had incurable transitional cell cancer, metastatic from the kidney. She had extensions of it up through her chest and a great deal of pain that had been steadily increasing. This type of cancer is about the least responsive of any to all of our orthodox methods of therapy, and I felt no compunction whatever about giving her anything she wanted. Her husband obtained Laetrile from a source in Miami, and I administered it in a fashion recommended by a physician in North Carolina with experience in the use of it.

Her response seemed quite encouraging for a while with regard to pain and other distress, and she required no more narcotics. Then after several months she suddenly announced that she didn't want to take any more of the Laetrile. Three days later she died in a rapid downhill course after having required almost no pain relief medication right up to the very end.

Was this a "good" result? Did the Laetrile simply provide psychological support?

I don't know.

The medical evidence to support the use of it is scientifically poor, but I think this could be because of the blind opposition; there is no sound, reasoned, and rational scientific disproof. Until the scientific evidence for it is better, I shall not propose Laetrile therapy to anybody, but I have been incensed for years at the stupidity of the opposition. The arrogant, pontifical assumption of omniscience by the Food and Drug Administration and the subservient arms of government is absolutely appalling to me. This governmental stupidity has directly produced a major, highly profitable black market and has resulted in many more Laetrile patient treatments than could ever have come about otherwise.

The recent action by the Florida Legislature was very encouraging, but it changed nothing for me. I was prepared, and still am, to administer anything in this category that is clearly free of harm. I seriously resent any government agency assuming such outrageous power.

If you obtain the material and can find no one else to administer it, I shall be glad to help you. I cannot help you further than that. Please phone me if you would like further information.

Sincerely yours,

W. E. Manry Jr., M.D.
Lake Wales

In addition to investigations conducted by the California Department of Public Health and by Canadian authorities, the National Cancer Institute has tested Laetrile in animals on five occasions between 1957 and 1975. Four independent cancer research centers undertook additional studies in 1975 and the Sloan Kettering Cancer Center is now conducting a "double blind" test in animals.

Laetrile: Do Some States Want Us To Smuggle It?

There are at least two issues involved in the action of the state legislatures permitting doctors in their state to administer laetrile to cancer patients. The first issue, Freedom Of Choice, is loudly acclaimed by a California based organization which has included the phrase in its name, Freedom of Choice in Cancer Therapy. This is really a semantic ploy, demagogically linking the guts of American Democracy, i.e., individual freedom, to a choice which demands highly specialized skills and critically gathered data before an informed judgment can be made, a judgment which is very difficult when there is "gold in the balance pans" to which I'll return a bit later.

The second issue is the issue of state's rights versus the federal government. The actions of Alaska, Indiana, and now Florida in sanctioning the use of Laetrile by their licensed physicians is in direct opposition to an action by the Food and Drug Administration which has banned its use because of lack of proof that laetrile has any effect on cancer. The ban is by a federal agency created by an act in 1938 to protect the consumer and replacing a similar but inadequate act passed in 1906. The 1938 act was passed immediately following a disastrous marketing of a chemotherapeutic agent in a toxic vehicle which killed many people. The act emphasized the need for establishment of safety in marketed drugs but paid little attention to the need for demonstration of efficacy. This was accomplished by the Harris-Kefauver amendments of 1963 which were passed following the near tragic introduction of the U.S. of a phocomelic drug and established the need to demonstrate efficacy of drugs as well as safety before marketing.

Okay—The 1963 amendments served to impede the approval of new drugs for marketing in the U.S., more than trebling the time required to obtain approval of a new drug for release in the U.S. and increased their cost in an already inflating economy. The FDA has been under constant attack and close surveillance, but despite its bureaucratic problems, it has survived and protected the consumer.

Okay again, there can be improvement in the administration of the agency. Let's get that done but not by bypassing the agency through state legislative action. The issue of state's rights, the doctrine of **nullification** (of acts of the federal government considered an invasion of its own rights) or of **interposition** (against the encroachment of sovereignty of a state by federal government) ought to be restricted to issues where both the federal and state governments have a choice of how to act. These are inapplicable to the highly technical issues concerned with the health of the people.

Freedom was once defined by Anatole France as "the right of the rich as well as the poor to sleep under the bridges of the Seine." Let us not redefine freedom of choice now as the right of the seriously ill person to select an unproved treatment for his disease and persuade the state legislatures to approve it with insufficient evidence of the efficacy and safety of the treatment.

I said I'd mention the problem of "gold in the balance of pan" affecting judgment. Recently, four persons have been convicted of conspiracy to smuggle laetrile from Mexico into the U.S. and then distribute it across the country (American Medical News, April 25, 1977, p. 14). Among those convicted were a physician, his business manager, the President of the Committee for Freedom of Choice in Cancer Therapy, Inc., and the Vice President of CFCCT. Developed during the trial was evidence that, within a 2½-year period, the physician's bank deposits had increased \$2.5 million while two of the three others each profited \$700,000 during the same period.

An excellent analysis of the problem and how to deal with it is set forth with customary brilliance and literacy by Franz Ingelfinger in his editorial of October 7, 1976 (New Eng. J. of Med., Vol. 295, p. 838) entitled "Quenchless Quest for Questionable Cure." In it he counterposes earlier editorials by Dr. Alfred Soffer and Peter M. Sandman, Ph.D., dealing respectively with the former's definition of scientific validity in evaluating a variety of nostrums, and with Sandman's exposition of "The fundamental law of communication: **you reach people by offering something they want.**"

Ingelfinger admits that his editorial review does not solve the problem of how to expose therapeutic fad. Sandman recommends that "among other things, doctors learn something about public relations, that they get acquainted with local reporters and broadcasters, and that they try to offer the media content that reinforces the needs, attitudes, or behaviors of the audience in a way that seems to yield the desired effect," and don't forget state legislators. Anyway, I don't see what help is given to the use of laetrile in the country by adding state legislative approval. Doesn't this, if it absolves the physician from responsibility, legitimize his smuggling or moonshining laetrile since the drug is federally banned from use in the U.S.?

Samuel C. Bukantz, M.D.
Tampa

Reprinted from The Editor's Column of the Bulletin of the Hillsborough County Medical Association, June 1977.

Laetrile Legislation — Innocuous?

A little child entered a hospital. Soon thereafter, the diagnosis of acute lymphoblastic leukemia was established.

The parents, however, in their contacts succeeded in contacting a medical physician who convinced them of the virtues of homeopathic measures, "mystic inner forces," and the dangers of standard treatment measures.

The parents sought to remove their child from the hospital. In an effort to protect the child, the involved physicians sought and obtained a temporary order restraining the parents from leaving the hospital with their little girl.

At the formal hearing before a judge, two different points of view were expressed — one based on absolutely no scientific evidence, and the other a resume of the latest knowledge in the treatment of this childhood malignancy. The judge ruled in favor of the parents, and the child left the hospital.

A week later, and because of the child's worsening condition, the parents brought her back to the hospital where appropriate treatment was instituted with an excellent initial response. Once the child was showing no evidence of disease, the parents decided to discontinue the chemotherapy. In its place, other measures were substituted — including Laetrile, "health foods," swami with their incantations, and darkened rooms filled with the sounds of records with strange songs.

Months went by and crucial months during

which time proven established therapy should have been continued.

The child, predictably, became sicker and sicker. With the increasing evidence of the failure of such measures, the parents again sought medical care. By this time, the child was in profound relapse. Her white count was skyhigh — comprised of many lymphoblasts. She was septic, emaciated, full of pain, and no longer able to walk. Again, she was started on a course of therapy. By now, however, her future is in doubt. Whereas before, she had a 75% chance of achieving a 5 year survival with remission of her disease, now her status is problematical.

What factors are highlighted by the preceding account?

1. The danger of passing seemingly innocuous laws that give statutory respectability to unproven, and at times dangerous, anti-cancer agents — for they encourage patients to depart from established treatment pathways — with the resultant horrendous consequences,

2. The need to take action against those members of our profession who advocate homeopathic measures, and

3. The need for the implementation of the guardian ad litem concept when the child appears in a court of law under child abuse statutes — i.e., a court-appointed individual who represents the rights of the child.

The Editor

A SCIENTIFIC TEST OF LAETRILE ON CANCER PATIENTS was called for by the National Council on Drugs. A controlled clinical trial "should be done under rigorous scientific conditions in a variety of selected cancer treatment centers, under the auspices of the National Cancer Institute in cooperation with the Food and Drug Administration," the council stated. The council is made up of eight national organizations, including the AMA. John A. Owen Jr. M.D., U. of Virginia School of Medicine, heads the council's Task Force on Laetrile. He said the test of the controversial substance "would guarantee for the cancer patient a completely legitimate opportunity to obtain laetrile of known strength and purity in a setting that would permit precise diagnosis of the disease and study of the treatment, and where any problem that arose could receive the best medical care available."

A new FDA report, calling the laetrile controversy "a life and death issue," said the substance is "not generally recognized as safe and effective" in cancer treatment. The report is the result of a court order requiring the FDA to compile an administrative record to support its contention that laetrile is a "new drug" and cannot be marketed without meeting the FDA's safety and efficacy standards. The AMA has supported the FDA's position.

A Statement

John E. Thrasher, J.D.

The "Laetrile Law" (Chapter 77-30, F.S.) has been variously interpreted by the public media and largely misinterpreted by most. Its four substantive Sections are straightforward:

Section 1 provides that a Florida licensed medical doctor or doctor of osteopathy may prescribe and administer laetrile when requested by a patient. Such prescription or administration shall not be construed as unethical by the hospital or health facility and no physician shall lose his staff privileges solely because of the prescribing or administering of laetrile.

Section 2 provides that no doctor of medicine or doctor of osteopathy shall be subject to disciplinary action by their respective licensing boards because of the prescribing or administering of laetrile.

Section 3 provides that the patient seeking laetrile shall be informed as to the alternative methods of treatment and their potential for cure. He shall sign a written release releasing the physician and, when applicable, the hospital or health facility from any liability for the administration of laetrile.

Section 4 directs the physicians to inform in writing any patient requesting laetrile that it has not been approved as a treatment or cure by the FDA.

The Florida Laetrile Law does not authorize manufacture of laetrile in Florida nor does it provide that laetrile shall be commercially available in Florida. The Law, in essence, simply decriminalizes the use of laetrile within Florida.

The following talk paper re: Laetrile vetoes, dated August 25, 1977 was issued by FDA:

Governor James R. Thompson of Illinois on August 24 vetoed a bill which would have permitted the use of Laetrile by physicians for terminal cancer patients. Governor Thompson's veto was the latest in a series of actions on the state level against Laetrile.

The California State Assembly Health Committee rejected a Laetrile Bill on August 8, following testimony by FDA Commissioner Kennedy and others. New York Governor Hugh Carey, whose wife died of cancer, vetoed on August 13 legislation passed by the state legislature.

The actions in California, Illinois and New York - three of the most populous states are significant in the effort to turn the tide against the enactment by states of Laetrile legislation.

Thus far, 12 states have passed Laetrile legislation. They are Alaska (in 1976), Arizona, Delaware, Florida, Indiana, Louisiana, Nevada, New Hampshire, Oklahoma, Oregon, Texas and Washington.

In his veto message, Governor Thompson said he believes that Laetrile is "totally ineffective in treating cancer." He said, "Laetrile has never been shown to be effective against cancer in any reputable clinical study. I cannot justify its use without becoming a hidden partner in deception. Use of Laetrile can only raise the hopes and lower the bank accounts of many very sick people." Discussing the concept of legalizing Laetrile only for the terminally ill, Governor Thompson said, "This argument is based on the assumption that we should not deny the dying patient any means of treatment he or she wishes. This is a compelling argument ... but there are tragic implications in following such a course. In some cases diagnosed as terminal, cancer patients recover for unknown or unexplained reasons. In these cases, if a patient had been taking Laetrile, the drug will be credited with the cure, despite no scientific explanation; the myth surrounding Laetrile, therefore, would continue. Diagnosis of a terminally ill patient is extremely difficult. U.S. Senator Hubert H. Humphrey of Minnesota was recently diagnosed as having terminal cancer, yet he has the prospect of many active years in the Senate with existing and proven cancer treatments. The State of Illinois cannot in good conscience sanction a choice between proven and unproven cancer treatment, when it could lead to the exclusive use of the unproven treatment. Recent tests show Laetrile can be a dangerous health hazard. As a substance containing cyanide, Laetrile has resulted in a death from internal consumption by an 11-month old girl and has produced the side effects of cyanide poisoning in others.

Mr. Thrasher is FMA Legal Counsel.

"The present federal ban on transportation of Laetrile, or substances for its manufacture, across state lines would create an Illinois Black Market because the needed species of plants do not exist in the state. Legalization of Laetrile in Illinois would, in effect, authorize the purchase of illegally imported quantities of the drug or the illegal importation of the raw materials to make it. It puts our stamp of approval on the Black Market.

"If Laetrile is legalized in spite of scientific evidence that it is useless as a cancer treatment,

then why not permit the sales of sawdust or Vitamin A as cancer cures . . . on the grounds that the terminally ill should have freedom of choice?

"Freedom of choice in a democracy always depends on accurate knowledge about the choices available. Very few citizens have the laboratory facilities to test Laetrile on their own and no cancer victim has the time. That is why it is very much the Government's responsibility to make a judgment about Laetrile on behalf of the people it represents."

Drug Information Highlights

LAETRILE

Also known as amygdalin and vitamin B-17, Laetrile occurs naturally in the pits of apricots, peaches and bitter almonds. The substance has been promoted as a cancer cure for almost 25 years even though there has never been any valid evidence which suggests that the substance is an effective anti-cancer agent. Studies to evaluate the anticancer effects of Laetrile have been conducted by the FDA, the Canadian Food and Drug Directorate, the National Cancer Institute and, in 1975, four independent cancer research centers. Clinical evidence that Laetrile alleviates or cures cancer is lacking.

The antitumor activity of Laetrile is proposed to be the release of free cyanide by the action of the enzyme B-glucuronidase which is claimed to be more prevalent in malignant tissue. The cyanide supposedly interferes with the respiratory apparatus of the tumor cell.

In examining the theoretical basis for this supposed action of Laetrile, it has been reported that beta-glucuronidase is found in all animal tissues, and is in a greater concentration in spleen and liver cells than in malignant cells. It was also found that Laetrile is not hydrolyzed to hydrogen cyanide in vitro by beta-glucuronidase under conditions of optimal activity of this enzyme. In addition, even if Laetrile were hydrolyzed, it has been shown that cyanide is not cancerocidal as long as glucose is available.

Recently, Laetrile supporters have changed their promotional tactics. It is now claimed that cancer is caused entirely by a deficiency of vitamin B-17 and that Laetrile is this vitamin. Statements promoting Laetrile often refers to "prevention," "relief of pain," "slows the cancer," "stops its spread," and other unproven claims.

In 1971, the FDA decided that Laetrile may not be promoted, tested or sold in the United States until the necessary basic studies had been completed. Nevertheless, proponents of Laetrile, notably the International Association of Cancer Victims and Friends (IACVF), the Committee for Freedom and Choice in Cancer Therapy, Dean Burk, Ph.D. (a retired employee of the NCI), Ernest Krebs, Jr. (whose father discovered Laetrile), and Dr. Ernesto Contreras (who operates a clinic in Tijuana), continue to sponsor conventions, films, and literature and will even make travel arrangements for victims to go to Mexico for treatment.

Laetrile is smuggled into the United States primarily from laboratories in Mexico and West Germany. The drug can be obtained in the United States on the black market at hugely

inflated prices. It was estimated in 1975, that \$40,000 worth of Laetrile crosses the border every day.⁴

State regulatory agencies have varied in their enforcement of the FDA regulations. In a case in Oklahoma, "Rutherford vs. United States," Mr. Rutherford was allowed to purchase and transport a 6 month supply of Laetrile for his own personal use. In most court cases the request has been denied. No court has authorized the sale of Laetrile in the United States or its importation for commercial distribution.

In 1976, Alaska passed a law prohibiting hospitals and health facilities from barring the use of Laetrile when prescribed or administered by a physician and requested by a patient. Legislation involving approval of Laetrile has been passed in Indiana and Florida, also.

A public hearing on the Laetrile controversy was held by the FDA on May 2 and 3, 1977, in Kansas City, Mo. Testimony heard at this hearing will be incorporated into an administrative record which is being compiled by the FDA on the Laetrile issues: The record to be compiled must deal with two basic issues: 1) whether Laetrile is exempt from the premarket approval (NDA) requirements for new drugs (by virtue of "grandfather" status) and 2) whether Laetrile is generally recognized as a safe and effective cancer drug by experts qualified by scientific training and experience to evaluate these issues:

On May 13, 1977, Governor Askew signed into law a bill legalizing the use of Laetrile for cancer patients in Florida. The Florida bill specifies that Laetrile can be administered only by a physician who must first inform the patient that the drug has not been approved by the FDA. There is no mention in Florida law of bringing the drug into the state and since the FDA has banned interstate transportation of Laetrile, it remains to be seen what effect the Florida law will have on the availability of Laetrile. The law takes effect on October 1, 1977 and will allow for the manufacture and distribution of Laetrile within state boundaries. The law does not legalize interstate shipment of the "drug" since that is solely the purview of the FDA.

The law is not based on any medical evidence or panel evaluations as are FDA rulings but is solely a bureaucratic maneuver to legalize administration of the "drug" in Florida by these physicians who choose to do so.

⁴ From Drug Information and Pharmacy Resource Center, College of Pharmacy, University of Florida, Gainesville.

Laetrile — When the Patient Asks

Eric J. Cassell, M.D.

In addressing the question of how a physician should respond if a patient with cancer asks — or even demands — “treatment” with laetrile, I believe one has to tackle a number of issues relating not only to the intertwined rights and prerogatives of both patient and physician but also to our perceptions of our roles as physicians individually, the relationship of the medical and governmental establishments to people, the symbolism of laetrile, and our attitudes toward death and toward disease that are likely to result in death.

First let me explain why I feel that laetrile has acquired a symbolic meaning even as Krebiozen did a generation ago. My friend Robert Veatch has remarked that the laetrile problem would disappear if it were to be classed as a food stuff made from apricots and placed on the druggist's shelf between Preparation H and lanolin. It would soon sink into deserved oblivion. Instead, it has come to stand, in the minds of a large public, for overregulation and overprotectionism by government and the “medical establishment,” who, like parents to young children, are always seen as placing themselves in a “we know best” stance of denial. And the public does not always think such things are done for their own good.

The sad fact that so many view physicians as participants in such a conspiracy of denial is eloquently attested to by the success of the pro-laetrile forces in various state legislatures. We should heed the lesson in the experience of the Governor of Indiana, a physician, who had laetrile legalized in his state over his veto. Perhaps even more pointed in terms of the individual physician is the phenomenon that has accompanied every hearing and legislative debate about laetrile — the parade of sick people who relate that the substance saved them when they had been given up as hopeless.

The words “hope” and “hopelessness” recur often in discussions about laetrile, and, indeed, they are very close to what I think is the basic problem. If I had to sum up that problem in a single sentence, it would be: When a cancer patient asks the physician for laetrile, there has been a breakdown in the care of the patient and in the doctor-patient relationship; and it is that breakdown, just as much as the disease, that has brought the patient to hopelessness.

This, of course, raises the question: What does a man or woman dying of metastatic cancer have to hope for? I recall a conversation once with a patient in this situation. She said to me: “There's no hope, is there?” My response was: “Do you mean there's no hope because you're going to die?” “No, no, everybody dies. I mean, there's no hope for survival.”

I had to ponder the meaning of this statement, and, together with many other experiences with patients with incurable disease, it has led me to feel very strongly that people with the knowledge of impending death do not become hopeless because of that knowledge. When they are told that they will die, they may react with sadness, depression, anger, or even tranquility — or perhaps with all of these — but not with hopelessness. What does

produce hopelessness (and I am convinced that this is what the woman was telling me) is the feeling that, as a result of disease, “I will cease to be myself, I will lose myself, I will lose control over the rest of my living.”

Sometimes patients reassert their control over their situation by refusing to comply with a treatment regimen. When this happens, the first thing the physician must remember is that he or she requires the patient's permission to render treatment, it is not the patient who requires the doctor's permission. Often simply acknowledging the patient's right of control will solve the problem. Of course, if noncompliance is equal to self-destruction, the doctor's responsibility is to explain this, and, if he desires, dissociate himself from the patient's action. But if the patient's attitude is “I know that I am harming myself but that is my right,” that position is incontrovertible.

On the other hand, a patient's refusal to comply with a drug regimen and, even more so, a patient's desire to resort to such quack remedies as laetrile are often like a sign going up at the bedside: “Hopelessness isn't being dealt with here.” Hope is a tomorrow word, and if someone is unable to find any meaning in today, and then tomorrow is also taken away, hope will be lost. And classically that is what so often happens to the cancer patient.

This danger of losing hope is particularly acute for the patient on chemotherapy. With surgery, there is always the hope that the scalpel will take the disease away.

But with chemotherapy, what do we do? We approach individuals who have had fear in the hearts from the moment of diagnosis (or in so many cases from the moment of suspicion), and that fear of pain, sickness, and death has been compounded by hopelessness because of their loss of control over their own existence, and we say to them: “We have these drugs.” But in order to make the drugs acceptable, we virtually tell the patient that this is all we can do for them. We need informed consent to start the chemotherapeutic regimen, and we read off a list of side effects and dangers that is almost lethal in itself. The chemotherapy becomes essentially the only sign of hope that we can offer, as though, when it fails, nothing is left, and as though we as physicians have no more to offer.

What's more, we often act as though we believe the same thing. As physicians, we tell ourselves, all we have to offer is chemotherapy. We confuse our tools with our role as physicians. We try to deal with the tumor cells with drugs but forget our huge capacity to deal with the fear and helplessness that often surround the patient. We talk about the care of the dying, and that is, perhaps, the root of the problem. The patient is alive — about to die, but alive. And like all the living, the patient needs information, needs to feel in control, and needs to take part in decisions. To pretend to such patients, when they want to know, that death is not in the picture, fools no one. All we do then is to push the patient into concealing from us his or her knowledge, which is the same as ours. We erect a barrier that makes it impossible not only to help the patient cope with the fear of dying but also with the problems of living: relationships within a family, maintenance of activities that the patient regards as part of self, holding on to dignity in the face of assaults by both disease and treatment. This is the type of help that physicians must offer over and beyond a regimen.

Dr. Cassell is Clinical Professor of Public Health at Cornell University Medical College, and Fellow of the Institute for Society, Ethics, and Life Sciences (Hastings Center). Dr. Cassell is author of *The Healer's Art* (J. B. Lippincott Company, Philadelphia, 1976).

It is my belief that when we fail to offer such care, then it becomes likely that the patient will turn to anything for help, and in the current situation, that anything is likely to be laetrile. If a patient tells me that he wants to try laetrile, my first question is: "Why?" Let's say the answer is "I don't want to die. I want to try anything." But, I must say, "this medicine doesn't offer you any additional hope for living. The cancer regimen you are now on, we think, can help you, and you can't take both the useful drugs and laetrile?"

"Why won't you give me laetrile?"

"Because I think it's wrong and will harm you and harm our relationship, because by taking it you will be fooling yourself. You'll be stopping yourself from dealing with what you have to deal with — how to handle your chemotherapy, how to get the most out of the life you have."

Even for patients in whom chemotherapy has failed, and who know it has failed, my answer to what harm can laetrile do

remains: "You have to deal with your life day to day, and I don't believe that you are doing that with laetrile. If you feel that you can't or don't want to do that, and want to take laetrile, there is nothing I can do to stop you, but I won't give it to you, and I won't sanction it."

This may sound pat out of the context of the relationship between the individual physician and the particular patient. It will not be pat if that relationship has provided the patient with the support and help so badly needed in coping with the effects of the disease on his or her life and in dealing with hopelessness. It is a measure of the failure of the medical profession in the United States to provide such support and help that laetrile can come along and become such a potent symbol of hope for the hopeless.

Reprinted from *Hospital Practice*, August 1977.



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A Radical Cure for High Medical Costs

Charles Peters

(Editor's Note: William G. Taylor, M.D., a Tampa plastic surgeon, obviously was distressed when he read "My Turn" by Charles Peters in the March 28, 1977 issue of *Newsweek*. It prompted Dr. Taylor to ask *Newsweek* for his turn, which at last report he had not gotten. Here, first, are excerpts from the Peters column, followed by Dr. Taylor's commentary).

"Practically everyone now realizes that we need some form of national health insurance. The problem is how to control its cost . . .

"Under the present system of health care, the providers of health services—the doctors and hospitals—not only set the price of the care but also decide what services will be furnished and where they will be available. Joseph Califano, the new Secretary of Health, Education and Welfare, is taking a first step toward doing something about holding down hospital costs, but no one is doing anything to control the doctors.

"This is not the way we have dealt with others in the business of protecting our lives: soldiers,

sailors, policemen, firemen. We tell them where to serve. The policemen can't all patrol Park Avenue . . . We do not permit even the greatest general to charge us whatever he wants.

"Is there any logical reason why medical salaries, specialties and places of work should not be equally subject to public control? Isn't the assurance of good medical care as important to you as the assurance of adequate protection by the police or the military? Shouldn't doctors be trained in the areas of medicine where they are needed and stationed accordingly? Shouldn't their income be geared, not to what they want, but to what the public can afford? . . ."

A Radical Cure for High Reading Costs

William G. Taylor, M.D.

Practically everyone now realizes that we need some form of national journalism control. As everyone knows and will admit, we are suffering from a poorly organized, misdirected, selfish, greedy writing profession and publishing industry, all going off into different directions at one time. These people are only interested in writing and/or publishing that which they want to write and publish in the way they see fit, charging whatever the traffic

will bear. This is a situation which has become intolerable, and the only method I can see is that of a government takeover of the present mess.

Writers set out with preconceived ideas, rejecting information and facts which do not agree with their already formed conclusions, which usually center around false, disrupting, and revolutionary concepts. Their books and articles are then printed and sold at outrageous prices,

misrepresented to the public as gospel truth.

It is apparent to anyone who has bought books or magazines that the cost of reading matter has simply gone out of sight. Many of us can remember when pocket books were 25¢ and popular magazines of the day cost 5¢ or 10¢. Now a pocket book can range up to \$3.00 per copy and magazines are from 75¢ to \$2.00. Newspapers which were 2¢ now cost us from 15¢ to 75¢, depending upon whether it is a daily or Sunday copy. This is an increase of from 750% to over 3,500%. It is common knowledge that writers are able to make obscene amounts of money, simply by writing and having published a popular book. Similarly, editors and publishers of these works are also grossly overpaid to the detriment of the public, because, it is the public who eventually pays for everything, including papers, magazines, books, entertainment, medical care, etc. It is inconceivable that this situation should continue to prevail, wherein the marketplace is permitted to determine the value of and availability of goods and services. By government nationalization, the percentage of our gross national product now devoted to this economic segment would be reduced to reasonable levels (I am not really sure what these levels are).

Is there any logical reason why sports and entertaining salaries, specialties and places of work should not be equally subject to "public" control, as well as those of journalists? The average NBA basketball player makes \$100,000 per six months' season, and not a few stage/screen entertainers demand and get hundreds of thousands for a few nights' work. Surely this qualifies as "indecent wealth", which in turn cries out for government control. Then these greedy people could also be obliged to play for the taxpayers of Boise, Wimauma and Cut and Shoot, in addition to all the big beautiful places.

Now some writers, editors, publishers and others mentioned, might object to this, however, we must consider that it is all in the public good. After all, they cannot all be editors or feature writers for *Newsweek*, *Time*, the *Chicago Tribune*, *New York Times*, *Washington Post*, etc. We also need writers for the rural weekly newspapers, regional magazines and trade publications of one kind or another. As a matter of fact, with an industry or business as vital to the survival of the United States as journalism is, I do not see how we can avoid providing some central direction and control, so that these resources will be properly allocated and priced within reason.

The more one ponders this concept the more apparent it becomes that controls over this segment of our society are absolutely necessary. As a matter of comparison, it should be noted that in some countries, for instance Russia, the reading matter is quite inexpensive and easily available to the public. There is no question as to the truth and applicability of that which is printed, because government sees to it. The writers editors, publishers, etc., are employed by the government. They are insured a decent living wage, and at the same time, the public is not defrauded by the exorbitant amounts of money that they would otherwise make. Other nations have also made examples for us. For instance, in the National Health Service of Britain, there was recently noted to have been approximately 600,000 patients on the hospital admission's waiting list.

The motivation for people to move into the field or area of journalism would then assume a more altruistic nature, because they would not be enticed by the greed revolving around the present economics. They would be moved by humanistic motives such as bringing truth and enlightenment to the population. After all, "indecent" wealth is rather base motivation for anyone's choosing a profession. Additionally, it is also undoubtedly right and proper that the Federal Government should be the deciding factor in establishing what "decent" wealth is versus "indecent".

It is becoming more obvious that we need more government planning and control, such as we have with the cost/efficiency factors involved in our post office operation. Bureaus and departments of the government operating for the public good have brought us school bussing to increase the quality of education, the Swine Flu Vaccine program and the proposal to ban the use of saccharin, etc.

As everyone knows, the Federal Government is far better able to provide goods and services at the most efficient level and lowest economic rate. Why should the business of writing and publishing (and the reading public) be denied these benefits of government wisdom?

Those who control what we read **must** be under our control. Maybe we could begin with Charles Peters and the *Washington Monthly*.

- Dr. Taylor, 4600 North Habana Avenue, Tampa 33614.

Emergency Medical Services

William C. Curry, Jr. and E. Charlton Prather, M.D.

Since the inception of the Florida EMS Act of 1973, this state has made significant strides in developing an on-going Emergency Medical Services Program. In these few short years Florida counties have developed from inadequate Emergency Medical Services Systems (i.e. little or no ambulance attendant training, no radio communications, inadequately equipped and designed ambulances) to sound "basic life support systems" as a minimum state-wide. Completed "Basic Life Support Systems" consist of:

1. Emergency Medical Technician training of at least 81 hours.
2. Radio communication between ambulance base stations and ambulances.
3. Ambulances which carry minimum equipment as recommended by American College of Surgeons, Trauma Committee.
4. Vehicles (ambulances) which meet or exceed State and Federal construction and design criteria as specified by Governmental Regulation KKK-A-1822.

During the first two years of the program's existence, Florida experienced a 27% decrease in traffic related deaths and a 21% decrease in non-traffic related accidental deaths. In addition, there has been a moderate decrease in heart related and cerebrovascular deaths.

The Florida Medical Association, American College of Emergency Physicians, Florida Chapter and the Emergency Department Nurses Association have contributed substantively to accomplishment of the goal of establishing a state-wide basic life support program.

The Florida Medical Association has identified Emergency Medical Services as a priority area for this year. Three elements are noted:

1. Establishment of a state-wide EMS Network;
2. Establishment of standards for optimal, critical care facilities; and

3. Active support of cardiopulmonary resuscitation (CPR) Life Support Training Programs.

In 1974 the State Division of Communications published a communications plan establishing a state-wide UHF communications system. All new or expanding EMS communication systems must obtain clearance from the Florida Division of Communications as a prerequisite to a Federal Communications Commission license. Upon full implementation of the plan Florida will have a state-wide communication network linking all regional and sub-regional hospitals, ambulance services and ambulances under a compatible communications system.

Federal Emergency Medical Services dollars received by Florida each year require that regional EMS systems be developed. Last year three Florida regions received money for EMS programming. Participating regions must comply with 15 elements of a basic life support system: treatment protocols, transfer agreements, mutual aid agreements and others.

The Florida Medical Association has actively supported a state-wide EMS network and is involved in the State EMS Advisory Committee through Dr. Roy Baker of Jacksonville, the current Committee Chairman. Other physicians on the State EMS Committee are Dr. Arthur L. Trask, Dr. Charles C. Hall, Dr. James L. Talbert, and Dr. David O. Westmark.

To establish standards for optimal, critical care facilities, the Florida Medical Foundation conducted a conference on the Identification of Needs and Standards for In-Hospital Critical Care in Tampa on September 11-12, 1976. The two universal problems of critical care — facility capability and clinical skills — were central to discussions. The conference concluded that:

1. Any patient whose clinical needs exceed the capability of a facility or physician should be transferred to a facility or physician who can provide optimal care for the particular patient.
2. A minimal experiential base is essential to maintenance of clinical skills to optimally

Mr. Curry is Public Information Officer, Emergency Medical Services, Department of Health & Rehabilitative Services, Tallahassee and Dr. Prather is Staff Director, Health Program Office, Department of Health & Rehabilitative Services, and an Associate Editor of the Journal.

deal with certain kinds of clinical problems. Therefore, mechanisms must be developed to assure the availability of an experiential base sufficient for maintenance of these skills.

The third EMS priority of the FMA this year is the Public CPR Project and Advanced Life Support (ALS) Training Programs (for training paramedics to administer drugs, start I.V.'s, intubate, and defibrillate emergency patients in the field under physician control and supervision). Association members and the Heart Association are encouraged to continue, as in the past, their active support toward the expansion of the EMS System to encompass Advanced Life Support. Approximately one-third of Florida's counties operate some type of Advanced Life Support Service at this time. The 1977 Florida legislature passed enabling legislation to standardize Florida's advanced life support program. The Florida Medical Association was of invaluable support in the development of this legislation and certainly their active assistance played a major part in the successful passage of this paramedic legislation.

Florida legislators are to be congratulated for their interest and desire to up-grade Florida's Emergency Medical Services Program and in particular Senators John Vogt, Ralph Poston and Representative Dr. Richard Hodes who introduced this legislation in the Florida Senate and House.

The Emergency Medical Services Section, Health Program Office, Department of Health and Rehabilitative Services with the cooperation and advice of the State EMS Advisory Committee, FMA Committee on EMS and The Emergency Medical Technician II Task Force Committee will be developing training guidelines, policies and procedures, and Rules and Regulations for the development of statewide uniform standards of compliance for paramedic services.

There are a number of Florida counties that have taken the lead in up-grading EMS and developed Advanced Life Support prior to the passage of the enabling legislation. Most of these counties developed outstanding programs that have substantively reduced the morbidity and mortality in their area. Such counties as Alachua, Broward, Duval, Dade, Hillsborough, Leon, Lee, Manatee and Pinellas, to mention a few.

Many others are in various stages of completing Advanced Life Support Services, but lacking equipment or sufficient numbers of paramedic personnel. Approximately \$900,000 has been requested by Governor Reubin O'D Askew from the

legislature to aid these counties in completing their systems. Other counties preparing to enter the Advanced Life Support Service level are Escambia, Santa Rosa, Okaloosa, Jackson, Bay, Baker, Columbia, Union, Bradford, Clay, Putnam, Nassau, St. Johns, Marion, Citrus, Volusia, Orange, Brevard, Osceola, Polk, Pasco, Okeechobee, St. Lucie, and Palm Beach.

The success of Florida's Advanced Life Support program will rely heavily on physician participation. County programs must have a Medical Director to supervise and accept responsibility for Emergency Medical Technicians and paramedics functioning for that county's EMS System. The support of the Florida Medical Association and Florida Chapter of the American College of Emergency Physicians will be vital if we are to require these physicians to participate in Advanced Life Support Programs.

It is, of course, unrealistic to assume that each and every emergency will result in an ambulance being on the scene within four to six minutes. FMA members are, therefore, encouraged to make every effort to inform those patients, whom they feel warrant it of the necessity to learn CPR. The State EMS office, as well as a number of county EMS services, are working with the Heart Association to train as many people as possible in basic life support (CPR) techniques. We encourage all physicians to become involved in their communities with promotion of and active participation in EMS public education projects.

The success of Florida's Emergency Medical Services program has been tied in closely with the involvement of the physician in our EMT training programs as well as the day to day operation of the EMS system. Continued physician involvement in our paramedic training programs will be essential to their success. American Heart Association Advanced Cardiac Life Support (ACLS) certification is a prerequisite for paramedic certification. There will be a tremendous need for ACLS physician instructors in the upcoming years to meet these training needs. It is hoped that Florida physicians will continue their active involvement in EMS and keep Florida a national leader in reducing prehospital morbidity and mortality.

The Florida Medical Association members are the most viable and respected source Florida has in encouraging those people who have a real need to know, to learn these life saving techniques. At least one member of a cardiac patient's family should know CPR. Every mother should know how to clear an airway obstruction.

CPR can save lives. Let's educate the public.

Monitor Mania vs Clinical Confidence

Robert E. Windom, M.D.

The physician who began practice more than five or ten years ago is constantly encountering new and sophisticated equipment which assists in patient care. Having little formal training in its development and operation he strives to obtain information which enables him to understand at least the superficial working of each type.

While the physician holds dear the education and training he received to attain the position of "full-fledged doctor," he may easily feel insecure with the newfangled device and be wary of having to respond to: "What does that do, doctor?"

The easiest way to handle most of these situations is to read about the equipment and to attend lectures or short courses to learn what it does and how it works. Then one will be better prepared to converse with a young technician or specialized therapist who has recently learned in a training program. The physician may have some reservation about admitting his ignorance but, with a little humility, barriers can be overcome.

The lack of some knowledge of the equipment might cause the patient or some other observer to believe that the physician does not have it "all together." Yet he learned about people by working closely with and upon them during his educational experiences. Utilizing true techniques of observation, palpation, percussion, and auscultation, he developed the ability to sense many deranged conditions which today are so readily subjected to mechanical and electronic scrutiny—often to the omission of tried and true, less sophisticated, applications.

The "older" physician may find himself alongside a group of allied health personnel working together to select the best approach to the sick patient. At this point observe how real are the differences in analyzing and evaluating the particular condition. A common statement may be: "Doctor, the monitor shows the heart rhythm to be irregular, the patient is unstable;" or, "the blood gases should be repeated often so we can tell whether to stop assisted ventilation." The doctor may assess that the patient's condition is stable regardless of the recorded values and may be steadily improving, not dependent upon the special equipment or

assistance, no matter what the "young scientist" says or thinks.

One must learn how to react to such situations as they are bound to occur with more frequency as medicine progresses further and into even more advanced technology. Turning away helps no one when it is apparent that a disagreement exists. Ridiculing the other person leads to poor communications in the future. There is but one satisfactory alternative. The physician should take the initiative and make it clear why his assessment of the patient's condition may result in a more accurate understanding of the situation. He must point out that the patient may function well with less than ideal results as reflected on the monitor screen or determined by the clinical analyzer. To know in greater depth the physiology and reaction to injury that the human body can manifest comes from much more medical training and experience than that attained by the majority of paramedical and allied health care associates. As a result, a firm basis of clinical confidence can be established. It often has greater sensitivity than any evaluation obtained from the monitor mania of individuals trained scientifically perhaps but with less perception of the broad flexibility of the human body.

Physicians should continue to rely upon clinical judgment and utilize the least amount necessary of mechanical assistance for patient care. The constant promotion of many gadgets and devices offering the latest technological assistance does not always reflect their true value. To be the newest does not mean to be the best. Monetary factors must also be considered and common sense should prevail when a specific device is selected, whether by the physician, hospital, or allied health personnel. Tried and true, often simple, techniques may produce better results in patient care than reliance upon new and expensive equipment that can be misused or abused easily.

As we continue on the various roads of progress, let us be mindful that our basic education and its fruits must be nurtured as we utilize clinical judgment to provide the best care possible. We must be cognizant of the increasing members on the team who now participate in each patient's care in or out

of the hospital. As this team enlarges, those joining the ranks must also remember that the physician is still the captain. Granted, every member should contribute significantly from his own talent; yet to become the captain requires a great deal more of education and experience. With cooperation and dedication toward the common goal of providing

the best in patient care, favorable results can be achieved in the most satisfactory manner for all concerned.

- Dr. Windom, 1750 South Osprey Avenue, Sarasota 33579.

The "Right" to Medical Care

John E. Thrasher, J.D.

The issue of National Health Insurance has been characterized by some individuals as an issue which allegedly involves the right of an individual to medical care. This so-called "right" has been perceived by some politicians and some members of the health care bureaucracy as being based on a principle that one person in our society has a "right" to demand and receive from another person in our society a particular service.

It is not clear from what source the individuals who advocate this type of doctrine find their authority. Clearly, such a right can be distinguished from the issue of discrimination based on race, creed and color, for example. Indeed, the Constitutional support against such discrimination on the basis of race, creed or color is clear; while any Constitutional support for the doctrine of one having the "right" to a service of another is found wanting. The right of an individual to request and receive a service from another individual in our society violates our basic freedoms so badly that one must wonder if we have not turned a corner and are not preparing to turn over to government our individual freedoms and dignity. Carried to the

extreme, this logic would provide a basis for any individual lacking in a specific need to receive it from another, even though the other person may wish to exercise his freedom of choice as to whom he offers his services and for what price. As responsible spokesman for the medical profession, we cannot allow our basic freedoms to be further eroded and handed over to government.

In the final analysis, the right to medical care is no different than, for example, the "right" to food or housing. The free market sets the standards and conditions for securing these so-called "rights"; and historically, our system has proven to be the most economical and efficient way of providing them. Many individuals, however, are being deceived by these individuals who use the "rights" issue to promote NHI, and who have not been honest in telling the people what the consequences of the acceptance of such a "right" will be. We cannot, as citizens and professionals, allow this kind of federal intervention to dictate to whom and how our services will be rendered. The price will be the loss of individual freedoms—a price we cannot afford to pay.

Mr. Thrasher is FMA Legal Counsel.



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ORGANIZATION

JFMA Captures Special Issue Award In Magazine Contest

The Special Issue on Neurological Surgery, published by *The Journal* one year ago, has won a first place award in the 21st Annual Magazine Contest sponsored by the Florida Magazine Association.

The judges singled out the neurosurgery number for the top prize in the "Best Special Issue" category, which drew 23 entries. In this division JFMA competed with special issues published by such magazines as *Florida Trend*, *Florida Agriculture*, *Florida Sportsman*, *Miami Magazine* and *Palm Beach Life*.

In its critique of the Neurological Surgery issue, the judges commented:

"This special issue does just what the introduction says it will do: 'provide the opportunity for physicians to be more aware of advances in the diagnosis and treatment of conditions amenable to

neurosurgical procedures.' It is organized in a logical, orderly manner; there's no extraneous material here. The articles are narrow in scope, cover a wide array of related topics, are short enough for rapid reading, and provide the necessary references. Truly a service issue for the membership and readership. A great job!"

Mrs. Louise Rader, Managing Editor of *The Journal*, accepted the award during the awards banquet held in conjunction with the annual convention of the Florida Magazine Association at Palm Coast on September 10.

The Neurological Surgery Issue was published in November 1976 in cooperation with the Florida Neurosurgical Society. Albert L. Rhoton, Jr., M.D., Professor and Chief of Neurosurgery at the University of Florida College of Medicine in Gainesville, was Guest Editor.

FMA President Appears Before Revision Commission

FMA President Louis C. Murray, M.D., outlined the need for a separate state health department during an appearance before Florida's Constitution Revision Commission in Tampa on August 29.

He appealed for the creation of a cabinet office of Secretary of Health which he said "would indicate that the health of our citizens has equal concern to that for agriculture, banking, education, and insurance."

"It would insure that Florida would once again be a leader in the nation in public health programs," he added.

Dr. Murray recalled that Florida's public health program was substantially reorganized in 1968,

when a Division of Health was created under a new Department of Health and Rehabilitative Services. A few years later, that Division as well as others in the Department were dismantled, and public health matters are now handled by a "health program office."

The need for a separate department of health has been proven through the years, Dr. Murray asserted.

"If we continue the breakup of this once effective mechanism, there is substantial danger of many of the old public health problems recurring with the concurrent adverse effect on our vital tourism and agricultural industries," he said.

Florida Magazine Association Elects JFMA's Executive Editor

Edward D. Hagan, Executive Editor of *The Journal of the Florida Medical Association*, has been elected Vice President of the Florida Magazine Association.

Mr. Hagan was elected to the post during the Association's 25th Annual Convention, which was held at Palm Coast, September 8-11. He succeeds Ms. Betty McDonell of Winter Park, Editor of *Gaslight News*, who was elected President.

The Florida Magazine Association is a trade organization representing the State's expanding magazine publishing industry. Its membership includes about 85 professional, trade, business,

special and general interest and other types of magazines with a combined circulation of more than 1.2 million.

Mr. Hagan has been a member of the Magazine Association since 1973, and has served for the past year as a member of its Board of Directors. A native of West Virginia and a graduate of Marshall University, he joined the Florida Medical Association staff in Jacksonville seven years ago. In addition to his editorial responsibilities, he serves as Director of the FMA Department of Scientific Activities.

Physician Recruitment Conference

The Florida Medical Association and the Florida Academy of Family Physicians will present a Physician Recruitment Conference in Gainesville this month.

The one-day session will be conducted at the Hilton Inn on Saturday, October 29. The meeting is expected to attract physicians seeking practice opportunities in Florida as well as community representatives.

The program:

"ABC's of Physician Recruitment" — Edgar J. Fisher Jr., Director of the Virginia Council on Health and Medical Care, Richmond.

"The History and World of a Family Practice in a Small Community—Bonifay" — Herb E. Brooks, M.D., and

Clara M. Brooks, Ph.D., Bonifay.

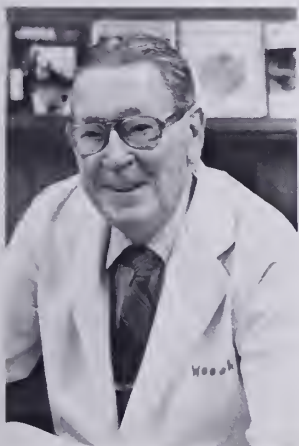
"North Arkansas Rural Health Project" — William Huddleston, Director, North Arkansas Human Services Center, Batesville, Ark.

"National Health Services Corps" — (Speaker to be Announced).

"Medical Manpower in Florida's Future" — Wilmer J. Coggins, M.D., Family Practice Program, University of Florida College of Medicine, Gainesville.

Advance registration, requiring a fee of \$10.00 (which includes lunch), is necessary. Information may be obtained by contacting the Committee on Rural Health, Florida Medical Association, P.O. Box 2411, Jacksonville, Florida 32203, telephone (904) 356-1571.

A. Ashley Weech, M.D.



Dr. Weech

Alexander Ashley Weech, M.D., 81-year-old nationally known pediatrician and Professor Emeritus of Pediatrics at the University of Florida, died at his home in Gainesville on September 17.

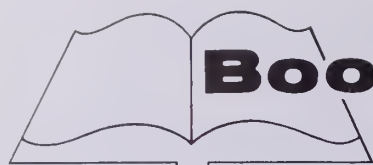
Dr. Weech, who was presented with the John Howland Award of the American Pediatric Society a few months ago, served as Professor and

Chairman of the Department of Pediatrics at the University of Cincinnati prior to relocating in Gainesville in 1973.

In 1935, Dr. Weech injected the first antibiotic in the United States, a dose of Protosil used in the care of a young girl with meningitis.

During a lifetime replete with professional honors and activities, Dr. Weech served as editor-in-chief of the *A.M.A. Journal of Diseases of Children*. He also served as President of the Society for Pediatric Research, the American Board of Pediatrics and the American Pediatric Society.

His widow, two children, two step-children, and 14 grandchildren and step-grandchildren survive.



Book Reviews

Book Review Editor

F. Norman Vickers, M.D.

Lupus — The Body Against Itself by Sheldon Paul Blau, M.D. and Dodi Schultz. 112 Pages. Price \$5.95. Doubleday & Company, Inc., Garden City, N. Y., 1977.

This book presents an admirable review of the collagen vascular disease, systemic lupus erythematosus, in terms understandable to the lay public. The monograph is readable, clearly written, and simple enough to be readily comprehended, but sufficiently complex to be informative.

Part I deals primarily with definition of the illness, its many presentations and clinical courses, helpful diagnostic tests and therapy. Part II details various endocrinologic, genetic, infectious and immunologic clues to the pathogenesis of this challenging disorder of unknown etiology. While both parts are interesting and potentially relevant, especially to sufferers of lupus, the first section probably will attract and hold the layman's attention more than the theoretical considerations given in the second section.

The section on therapeutics outlines current recommendations for the use of anti-inflammatory agents, antimalarials, corticosteroids and immunosuppressants, and provides numerous helpful clues to the lupus patient. Advice regarding vaccinations, choice of cosmetics, deodorants and medications, sun and cold exposure, and numerous other matters may help reduce circumstances likely to exacerbate the illness.

In summary, this book should be welcomed by lupus sufferers and other lay readers interested in the disease. I do not regard it as a contribution primarily for physicians; however, I am delighted to have it on my bookshelf and will encourage my lupus patients to read it thoroughly.

Norman L. Gottlieb, M.D.
Miami

How to Feed Your Hyperactive Child by Laura J. Stevens, George E. Stevens and Rosemary B. Stoner. 240 Pages. Price \$7.95. Doubleday & Company, Inc., Garden City, N.Y., 1977.

Laura Stevens is the mother of a hyperactive child and the organizer of Parents of Hyperactive Children; George Stevens is Associate Professor of Communication at Purdue University, and Rosemary Stoner worked for several years in the Foods Division of Procter & Gamble.

Rosemary Stoner had a hyperactive son whose treatment failed to produce a satisfactory result. In the midst of her despair she read Feingold's book "Why Your Child Is Hyperactive." Her pediatrician said there was nothing to lose in trying the diet as he had had success with it in other patients, suggested it be tried and the child improved remarkably.

The idea for a cookbook was born and Mary Stoner, whose family was on the diet, collaborated. The book contains 400 recipes which delete food additives and salicylates from the diet. These have been supplied by parents of hyperactives and tested by dieticians for nutritional value, accuracy, and economy. It is also suggested that any child on this program be followed by his pediatrician or physician. This diet works in about 50% of hyperactive patients. Personal determination on the part of the parent, the child's dedicated help, and the correct attitude of the family are also necessary to insure success. This book makes the task of feeding much easier for the parent and family as they deal with a difficult form of therapy.

Perry A. Sperber, M.D.
South Daytona

Dr. Gottlieb is Associate Professor of Medicine, Arthritis Division, University of Miami School of Medicine.

Dr. Sperber is retired from the practice of Dermatology.

Books Received

Receipt of the following books is acknowledged. Medical readers interested in reviewing particular books are invited to address requests to the Book Review Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.

Healthy Pregnancy — The Yoga Way by Judi Thompson (Foreword by James C. Baker, M.D.). 148 Pages. Illustrated. Price \$3.95. Doubleday & Company, Inc., Garden City, New York, 1977.

BT Behavior Therapy, Strategies for Solving Problems in Living by Spencer A. Rathus, Ph.D. and Jeffrey S. Nevid, Ph.D. 314 Pages. Illustrated. Price \$8.95. Garden City, New York, Doubleday & Company, Inc., 1977.

Income Redistribution, edited by Colin D. Campbell. 267 Pages. Price \$4.75 (paperback) \$9.75 (cloth). Washington D.C., American Enterprise Institute for Public Policy Research, 1977.

Handbook for Differential Diagnosis of Neurologic Signs and Symptoms by Kenneth M. Heilman, M.D., Robert T. Watson, M.D. and Melvin Greer, M.D. 231 Pages. Illustrated. Price \$8.95. New York, Appleton-Century-Crofts, 1977.

Labor & Delivery, An Observer's Diary by Constance A. Bean with an introduction by Gerald Cohen, M.D., 203 Pages. Price \$7.95. Garden City, New York, Doubleday & Company, Inc., 1977.

Controlled Substances Inventory List, by the United States Department of Justice, Drug Enforcement Administration. 293 Pages. Washington, D.C., 1977.

Handbook of Obstetrics & Gynecology, 6th Ed. by Ralph C. Benson, M.D. 772 Pages. Illustrated. Price \$9.50. Los Altos, Calif., Lange Medical Publications, 1977.

General Ophthalmology, 8th Edition, by Daniel Vaughan, M.D. and Taylor Asbury, M.D. 379 Pages. Illustrated. Price \$12.00. Los Altos, California, Lange Medical Publications, 1977.

Review of Medical Physiology, 8th Edition, by William F. Ganong, M.D. 599 Pages. Illustrated. Price \$12.50. Los Altos, California, Lange Medical Publications, 1977.

The Nervous System by William F. Ganong, M.D., 226 Pages. Illustrated. Price \$8.00. Los Altos, California, Lange Medical Publications, 1977.

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 Limp like a wet tissue . . .
 Churning, yearning for lost relationships . . .
 Weeping, crying for happier childhood days

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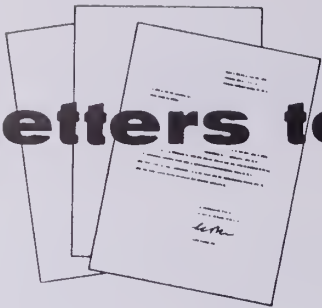
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Letters to the Editor

To The Editor: The Supreme Court of the State of Florida, in an opinion filed July 14, 1977, has rejected a proposal by the Florida Bar to impose a maximum legal fee in cases where the fee is contingent upon the recovery of money or other property by the client of original jurisdiction. This case has been pending before the Supreme Court for over a year. The Florida Medical Association, Inc., appearing in the case as an interested party has asserted that the maximum fee schedule proposed by the Florida Bar should be more restrictive.

The Supreme Court in rejecting arguments for a maximum fee schedule for contingency fees expressed the view that there was an "absence of competent evidence demonstrating any significant abuse of the contingent fee arrangements." Moreover, the court said that imposing a maximum contingent fee schedule on lawyers would impinge upon the constitutional guarantee of freedom to contract so long as no fraud or deception is practiced and the contracts are legal in all respects. The court emphasized that there was "no more national basis to adopt the suggested maximum fee schedule than there is to establish such maximum on the fees contracted for by architects, engineers, accountants or physicians." The court did however

feel certain reforms were needed relative to division and disclosure of fees in personal injury cases. In this regard the court adopted new disciplinary rules for lawyers to provide that:

- 1) The client is made aware that the forwarding attorney is participating in the fee and to what extent.
- 2) The client must consent to the fee arrangement in writing and the agreement must be signed by our client and all attorneys representing the client.
- 3) The forwarding attorney assumes the same legal responsibility to the client for the performance of the services in question as if the attorney or law firm were a partner of the other attorneys involved.
- 4) In the event of a recovery the attorney shall prepare a closing statement for the client reflecting an itemization of all costs and expenses, together with the amount of fee received by each participating attorney.

John E. Thrasher, J.D.
FMA Legal Counsel

Physician's Assistants To Earn B. S. in Medicine

The University of Florida will begin to award degrees of Bachelor of Science in Medicine to graduates of its Physician's Assistant program for students entering this fall.

The baccalaureate program was approved by the Florida Board of Regents. The PA program was begun in 1972 and since then the 91 graduates of the program have been awarded Associate of Science degrees from Santa Fe Community College and certificates from the University's College of Medicine.

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Calvin Hudson, M.D.
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Division of Neurosurgery
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Univ. of Pittsburgh
School of Medicine

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Edward L. Hogan, M.D.
Professor & Chairman
Department of Neurology
Medical University of
South Carolina

Leon D. Prockop, M.D.
Professor and Chairman
Department of Neurology
Univ. of South Florida
College of Medicine

Robert R. Young, M.D.
Assoc. Professor of Neurology
Dir. of Clinical Neuro-Physio Lab
Massachusetts General Hospital

SATURDAY MORNING, Schultz Auditorium

10:00 - Past, Present & Future of **"Evoked Visual,
11:00 a.m. Auditory & Sensory Potentials"**

SATURDAY AFTERNOON — Schultz Auditorium

12:30 p.m. Registration
1:30 p.m. **"The Current State of Electromyography"**
— Robert Young, M.D.
2:00 p.m. **"Head Injury & EEG"**
— Frederick Gibbs, M.D.
3:00 p.m. Coffee Break
3:15 p.m. **"The Diagnosis & Treatment of Multiple Sclerosis"**
— Edward L. Hogan, M.D.
4:00 p.m. Panel Discussion with Drs. Gibbs, Hogan & Young
Moderator: Jacob Green, M.D., Program Chairman
4:30 p.m. Adjourn

SUNDAY MORNING — Schultz Auditorium

9:00 a.m. **"Update on Stroke Therapy, the Use of Steroids
In Stroke Patients"**
— Oscar Reinmuth, M.D.
9:45 Coffee Break
10:00 a.m. **"The Current Management of Headaches"**
— Melvin Greer, M.D.
10:45 a.m. **"The Work-Up and Treatment of the Patient with
Neuropathy"**
— Leon D. Prockop, M.D.
11:30 a.m. **"Dorsal Column Stimulation in Multiple Sclerosis
Patients"**
— Calvin Hudson, M.D.
12:15 p.m. Panel Discussion with Drs. Greer, Hudson
Prockop and Reinmuth
12:45 p.m. Adjourn

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Francis C. Coleman, M.D., of Tampa . . . has been appointed to the Special Committee on the Nation's Health Care Needs of the Chamber of Commerce of the United States.

The principal goal of the Committee is to develop National Chamber policy on health related issues, including cost containment, national health insurance, Medicare and Medicaid reform, and prepaid health plans.

Medic Alert Foundation of Turlock, California . . . has opened a regional office in Orlando under the direction of Mr. William B. Sturm of Brooksville.

Mr. Sturm is a former emergency medical services consultant to the State of Florida. The new office is located at American Pioneer Center, Suite 410, 600 Courtland St., Orlando 32804, telephone (305) 647-2497.

Medic Alert is a nonprofit foundation which provides a total system of emergency medical identification for individuals with such afflictions as diabetes, heart conditions and severe allergies.

Michael H. Ross, Ph.D. . . . has been appointed Chairman of the University of Florida College of Medicine's new Department of Anatomy.

Dr. Ross, who earned his doctorate at New York University School of Medicine, joined the University of Florida in 1971. He was chief of the Division of Anatomical Sciences within the Department of Pathology until the new department was created.

The Florida Medical Political Action Committee . . . is sponsoring a North Florida FLAMPAC Workshop in Tallahassee, October 22-23. The session will begin with registration at 7:00 a.m. at the Tallahassee Hilton.

The program will include a report on the 1977 legislative session, discussion of political action techniques, candidate selection committees and other subjects.

Information may be obtained by contacting North Florida FLAMPAC Workshop, 100 East College Ave., Tallahassee, FL 32301.

A Record Freshman Class of 139 Students . . . began their medical education at the University of Miami School of Medicine in September. Twenty-five women are included.

Miami's total enrollment of 613 also is a record. They include 142 seniors, 138 juniors, 137 sophomores and 57 students enrolled in a two year course for persons already holding Ph.D. degrees to earn M.D.s.

James A. Alexander, M.D. . . . has been appointed chief of the Division of Thoracic and Cardiovascular Surgery at the University of Florida College of Medicine. Dr. Alexander formerly was Associate Chief of Thoracic Surgery at Children's Hospital in Philadelphia, and Assistant Professor of Surgery at the University of Pennsylvania.

A 1966 graduate of Duke University Medical School, Dr. Alexander stayed on there for eight years of internship and residency training. He is certified by the American Board of Surgery and the American Board of Thoracic Surgery.

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Program Highlights

9 Postgraduate Courses—This large selection of Category 1 courses allows you to concentrate in those areas in which you want to update and upgrade your medical knowledge and skills (See overleaf.)

Videoclinics, 6 Telecourses, 2 Motion Picture Seminars, 8 State of the Art Lectures, 9 Dialogues—All of these events are Category 1 and free of charge (except the videoclinics). It means you could earn up to 20 hours of Category 1 CME credit *without any cost to you.*

Scientific Exhibits—These presentations highlight research being done in medical schools, hospitals, and research institutes, and provide an ideal one-to-one learning experience.

Industrial Exhibits—More than 80 firms will exhibit an array of new products and services that are indispensable to medical practice.

See overleaf for complete listing of postgraduate courses

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AMA 31st Winter Scientific Meeting

POSTGRADUATE COURSES

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Basic Electrocardiography
Thyroid Disease: Diagnosis and Management
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Advances in Rheumatoid and Collagenous Vascular Disease: Diagnosis and Therapy
Fetal Assessments—Monitoring
Ophthalmology for the Nonophthalmologist
Medical and Surgical Management of Skin Cancer
Basic Life Support—CPR
Fluid and Electrolyte Balance
Hypoglycemia: Diagnosis and Management
Diagnosis and Treatment of Fractures of the Lower Extremities
Medical and Surgical Management of Coronary Vascular Disease
Noninvasive Diagnostic Radiological Techniques
Dermatology for the Nondermatologist
Sports Injuries
Biofeedback and Other Techniques
Clinical Aspects of Immunology
Diabetes: Diagnosis and Management
Psychotropic Drugs: Uses and Abuses
Unsticky Platelets—Loose Clots
Infectious Diseases in Children
Office Gynecology
Drugs: Actions, Reactions, and Interactions
Care of the Critically Ill: Medical and Surgical Management
Office Endocrinology
Newer Clinical Approaches to the Sexually Transmitted Diseases

Diagnosis and Treatment of Fractures, Dislocations, and Epiphyseal Injuries in Children
Advanced Life Support—Cardiopulmonary Resuscitation (CPR)
Medical and Emotional Problems of Aging
Hypercalcemia: Diagnosis and Management
Evaluation and Management of the Jaundiced Patient
Pediatric Feeding and Nutritional Problems
Office Neurology
Psychiatry for the Nonpsychiatrist
Indications for Total Joint Replacement
Management of Acute and Chronic Pulmonary Problems
Evaluation and Management of Hyperlipidemias
Emergency Medicine for 1978
Pediatric Allergy and Immunology
Management of Renal Failure
Management of Hepatic Problems
Diagnosis and Treatment of Fractures of the Upper Extremities
The Integration of Adjuvant Modalities in the Treatment of Cancer
Nephrolithiasis: Diagnosis and Management
Evaluation and Management of Arrhythmias
Current Antibiotic Uses and Abuses
Evaluation and Management of Common GI Problems
Office Orthopedics
Evaluation and Management of Common Urinary Tract Problems
Use and Consequences of Steroids
Exercise Testing and Physical Fitness Proficiency
Advances in Antibiotics and Other Antimicrobials
Evaluation and Management of Seizure Disorders
Evaluation and Management of GI Bleeding
Alcohol and Drug Abuse
Advanced Electrocardiography

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MEETINGS

Approved by FMA Committee on Continuing Medical Education

NOVEMBER

Venereal Disease: The Laboratory, Nov. 3, University Health Center, Tallahassee. For information: Philip Rond, M.D., University Health Center, Tallahassee 32306.

Fall Meeting of the Florida Society of Ophthalmology, Nov. 3-6, Sandpiper Bay, Port St. Lucie, Florida. For information: Susan Waits, Suite 400G, Barnett Bank Building, Tallahassee 32301.

Trauma Symposium, Nov. 5-6, North Ridge Hospital, Fort Lauderdale. For information: Edgar H. J. Hift, M.D., 5757 North Dixie Highway, Fort Lauderdale 33334.

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Nov. 7-12, Miami.*

Seventh George Papanicolaou Memorial Seminar, Nov. 9, Dallas, Texas. For information: George Ioannides, M.D., Dept. of Path., St. Francis Hospital, Miami Beach 33141.

Colonoscopy Indications, Application and Interpretation, Nov. 9, Auditorium, Naples Community Hospital, Naples. For information: Albert L. Kerns, M.D., F.A.C.P., Chairman, Department of Medicine, Naples Community Hospital, 350 7th St. South, Naples, 33940.

Pars Plana Vitreous Surgery — The Miami Technique, Nov. 10-12, Miami.*

Antibiotic Selection and Use, Nov. 11, Veterans Administration Center, Bay Pines. For information: John C. Gallagher, M.D., Veterans Administration Center, Bay Pines 33504.

The Eye in Family Practice, Nov. 11-12, Miami.*

Advances in Infectious Diseases, Nov. 12, Gainesville.**

Seminar in Spanish: Cardiology, Endocrinology, Gynecology, Nov. 15-16, Miami. For information: Thelma Mac Gregor, Education Department, Cedars of Lebanon Health Care Center, P.O. Box 520793, Miami 33152.

Knee Injuries and the College Student, Nov. 17, University Health Center, Tallahassee. For information: Philip Rond, M.D., University Health Center, Tallahassee 32306.

Update in Gastrointestinal Disease, Nov. 17-18, Miami. For information: Thelma Mac Gregor, Education Department, Cedars of Lebanon Health Care Center, P.O. Box 520793, Miami 33152.

Pediatric Hematology, November 19, Gainesville.**

Weekend in Neurology, Nov. 19-20, St. Vincent's Medical Center, Shultz Auditorium, Jacksonville. For information: Nancy Huckins, JHEP, 655 W. 8th Street, Jacksonville 32209.

Clinical Application of the Intra-Aortic Balloon Pump, Nov. 25-27, Miami.*

DECEMBER

Laparoscopy: Diagnostic and Therapeutic Techniques, Dec. 1-3, Contemporary Resort Hotel, Lake Buena Vista. For information: H. Worth Boyce, Jr., M.D., 12901 North 30th St., Tampa 33612.

Basic Clinical Electrocardiography and Arrhythmia Management, Dec. 2-4, Royal Biscayne, Miami. For information: William E. James, Ph.D., One Inverness Drive, Englewood, Colorado 80110.

Pediatric Nephrology and Gastroenterology, Dec. 3, Gainesville.**

The Vitreous, Dec. 7-9, Miami.*

Pediatric Anesthesia, Dec. 8-11, Miami.*

Medical Surgical Seminar, Dec. 9-10, St. Francis Hospital, Miami Beach. For information: Lawrence R. Medoff, M.D., 250 West 63rd Street, Miami Beach 33141.

5th Annual Symposium on the Management of Sexual Problems, Dec. 9-11, Gainesville Hilton, Gainesville.**

Intraocular Lenses, Dec. 12-15, Miami.*

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Dec. 12-17, Miami.*

1978

JANUARY

Fifth Annual Symposium in Pediatric Nephrology: Current Concepts in Diagnosis and Management, Jan. 4-7, Miami.*

Fifteenth Annual Postgraduate Seminar in Anesthesiology, Jan. 5-8, Americana Hotel, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

Cardiac Arrhythmias, Jan. 6-8, Omni International Hotel, Miami. For information: Ralph Lassara, M.D., Veterans Administration Hospital, 1201 N.W. 16th Street, Miami 33125.

*For information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152, Tel. (305) 547-6716.

**For information: Contact Division of Continuing Education, Box J-223, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143.

+For information: Contact Theron A. Ebel, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2074.

Miami Winter Symposia, Jan. 9-12, Miami.*

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Jan. 9-14, Miami.*

Third Annual Seminar, "Problems in Pediatric Radiology," Jan. 13-17, Sonesta Beach Hotel and Tennis Club, Key Biscayne.*

Postconvention Seminar in Pediatric Radiology "Radiographic-Pathologic Correlation of Pediatric Diseases," Jan. 17-20, The Colony Beach and Tennis Resort, Sarasota.*

Art and Science in the Therapy of Difficult Problems in Surgery, Jan. 18-21, Miami.*

10th Annual Postgraduate Seminar in Pediatric & Adult Urology, Jan. 19-21, Carillon Hotel, Miami Beach. For information, Victor Politano, M.D., 3900 Northwest 79th Ave., Suite 469, Miami 33166.

Advances in Endocrinology '78, Jan. 20-21, Hyatt House, Kissimmee. For information: Samuel E. Crockett, M.D. or Barry E. Seiger, M.D., 1416 S. Orange Avenue, Orlando 32806.

Corneal and Plastic Ophthalmic Surgery and Diseases of the Eye, Jan. 22-27, Miami.*

3rd Annual Review and Recent Practical Advances in Pathology, Jan. 22-27, Miami.*

A Neurological Update: 1978, Jan. 23-27, Miami.*

3rd International Symposium on Stress, Jan. 26-27, Gainesville Hilton, Gainesville.**

Cancer Chemotherapy, Jan. 27, Veterans Administration Center, Bay Pines. For information: John C. Gallagher, M.D., Veterans Administration Center, Bay Pines 33504.

Cancer Chemotherapy, Jan. 27, VA Center, Bay Pines. For information: John C. Gallagher, M.D., Chairman, Education Committee, VA Center, Bay Pines 33504.

Coronary Disease, Exercise, Testing and Cardiac Rehabilitation, Jan. 27-29, Orlando Hyatt House, Orlando. For information: William E. James, Ph.D., One Inverness Dr., Englewood, Colorado 80110.

Thirteenth Annual Scientific Assembly of the American Society of Contemporary Medicine and Surgery, Jan. 30-Feb. 3, Americana Hotel, Miami Beach. For information: John G. Bellows, M.D., 6 North Michigan Avenue, Chicago 60602.

FEBRUARY

Twelfth Annual Symposium on Cosmetic Surgery, Feb. 2-4, Cedars of Lebanon Hospital, Miami. For information: Thelma MacGregor, Seminar Sec., Cosmetic Surgery Symposium, Cedars of Lebanon Hospital, 1400 NW 12th Avenue, Miami 33136.

23rd Central Florida Medical Meeting, Feb. 3-5, Contemporary Resort Hotel, Orlando. For information: Edward Ackerman, M.D., 800 West Morse Blvd., Winter Park 32789.

Management of Cardiac Disease — 1978, Feb. 3-5, Omni International Center, Miami. For information: Robert J. Myerburg, M.D., and Agustin Castellanos, Jr., M.D., Division of Cardiology, University of Miami, P.O. Box 520875, Miami 33152.

Fourth Annual Fall Conference in Anesthesiology, Feb. 4-11, Miami.*

OB-GYN Caribbean Seminar, Feb. 4-11, Miami.*

Thirteenth Annual Postgraduate Course — Internal Medicine 1978, Feb. 5-10, Sheraton Four Ambassadors Hotel, Miami. For information: J. Bocles, M.D., University of Miami School of Medicine, Department of Internal Medicine, P.O. Box 520875, Miami 33152.

Clinical Nephrology and Hypertension, Feb. 6-8, Doral Beach Hotel, Miami. For information: Office of CME Mount Sinai Medical Center, 4300 Alton Road, Miami Beach 33140.

Florida Midwinter Seminar in Ophthalmology, Feb. 6-8, Miami.*

13th Annual "Internal Medicine 1978," Feb. 6-11, Miami.*

Florida Midwinter Seminar in Otolaryngology, Feb. 9-11, Miami.*

Internal Medicine Update '78, Feb. 13-18, Dutch Inn, Lake Buena Vista. For information: Barry E. Sieger, M.D. or Samuel E. Crockett, M.D. or Roy Behnke, M.D., 1416 S. Orange Avenue, Orlando 32806.

Basic Clinical Electrocardiography and Arrhythmia Management, Feb. 17-19, Bahia Mar, Fort Lauderdale. For information: William E. James, Ph.D., One Inverness Drive, Englewood, Colorado 80110.

Pediatric Dermatology Seminar, Feb. 23-26, Konover Hotel, Miami Beach. Program to be followed by a one week post seminar flight and cruise to the Caribbean and South America. For information: Guinter Kahn, M.D., 16800 N.W. 2 Ave., Suite 401, N. Miami Beach 33169.

Basic Neurology for Psychiatrists, Family Practitioners and General Practitioners, Feb. 26-Mar. 3, Miami.*

MARCH

Hepatobiliary Disease in Clinical Practice, Mar. 2-4, Miami.*

5th Annual Selected Topics in Urology, Mar. 2-4, Gainesville Hilton, Gainesville.**

First International Congress on Colonoscopy and Diseases of the Large Bowel, Mar. 2-4, Fontainebleau Hotel, Miami Beach. For information: John P. Christie, M.D., 7400 N. Kendall Drive, Suite 311, S. Miami 33156.

Perinatology II High Risk Pregnancy Conditions and Their Management, Mar. 2-4, Hyatt House, Orlando. For information: Amelia C. Cruz, M.D., University of Florida College of Medicine, Department of Obstetrics and Gynecology, Box J-294, JHMC, Gainesville 32610.

Management of Diabetes Mellitus, Mar. 3, Veterans Administration Center, Bay Pines. For information: John C. Gallagher, M.D., Veterans Administration Center, Bay Pines 33504.

3rd Annual Conference in Skin Disorders for Nurses, Mar. 3-5, Miami.*

Postgraduate Seminar in Dermatology, Mar. 3-5, Miami.*

Eighth Annual Radiological Special Procedures Seminar, Mar. 4-7, Konover Hotel, Miami Beach. For information: Mrs. Lucy Kelley, 6752 S.W. 34th Court, Miramar 33023.

16th Annual Clinical Radiology Seminar "Controversies in Radiology", Mar. 7-11, Konover Hotel, Miami Beach. For information: Mrs. Lucy Kelley, 6752 S.W. 34th Court, Miramar 33023.

2nd Annual Seminar "Practical Aspects of Computed Tomography", Mar. 12-15, Konover Hotel, Miami Beach.*

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Mar. 13-18, Miami.*

Practical Aspects of Ultrasonography, Mar. 15-18, Konover Hotel, Miami Beach.*

Infectious Disease and Immunology, Mar. 17-18, Dutch Inn, Lake Buena Vista. For information: Barry E. Sieger, M.D. or Samuel E. Crockett, M.D., 1416 South Orange Avenue, Orlando 32806.

Postconvention Seminar Bahamian Cruise, Mar. 17-20, Nassau, Bahamas.*

Current Clinical Concepts in Otolaryngology, 1978, Mar. 22-24, Miami.*

10th Teaching Conference in Clinical Cardiology, Mar. 22-25, Miami.*

Tenth Teaching Conference in Clinical Cardiology, Mar. 22-25, Americana Hotel, Miami Beach. For information: Michael S. Gordon, M.D., Ph.D., University of Miami School of Medicine, Division of Cardiology, P.O. Box 520875, Biscayne Annex, Miami 33152.

9th Annual Topics in Internal Medicine, Mar. 23-25, Gainesville Hilton, Gainesville.**

APRIL

Malignant Hyperthermia, Apr. 6-9, Miami.*

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Apr. 10-15, Miami.*

Sixth Annual Intensive Care Symposium, Apr. 15-17, Miami.*

Emergencies in Internal Medicine, Apr. 17-20, Miami.*

Advanced Electrocardiography and Arrhythmia Management for the Family Practitioner, Apr. 20-22, Gainesville Hilton, Gainesville.**

MAY

Second Annual Symposium on Underwater Medicine, May 4-8, Miami.*

Seizure Disorders, May 5, Veterans Administration Center, Bay Pines. For information: John C. Gallagher, M.D., Veterans Administration Center, Bay Pines 33504.

Seizure Disorders, May 5, VA Center, Bay Pines. For information: John C. Gallagher, M.D., Chairman, Education Committee, VA Center, Bay Pines 33504.

Post-Convention Seminar and Diving Program, May 8-11, Miami.*

Pars Plana Vitreous Surgery - The Miami Technique, May 11-13, Miami.*

Family Medicine Update — 1978, May 18-21, Miami.*

7th Family Practice Review, May 22-26, Gainesville Hilton, Gainesville.**

JUNE

Review Course for Certification in Internal Medicine, June, Miami.*

Bascom Palmer Eye Institute Alumni Meeting and Seminar, June 9-11, Miami.*

Coronary Disease, Exercise Testing and Cardiac Rehabilitation, June 23-25, Orlando Hyatt House, Orlando. For information: William E. James, Ph.D., One Inverness Drive, Englewood, Colorado 80110.



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But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

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2-mg, 5-mg, 10-mg scored tablets
a prudent choice in psychic
tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.
Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.

Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

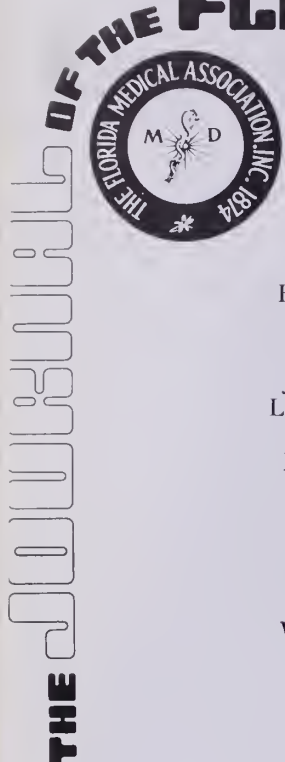
Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

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NOVEMBER COVER — The November cover highlights the central theme of the lead article in this issue on page 757. It was drawn especially for the Journal by Dr. Robert G. Iglesias, an otolaryngologist in Tampa.

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The object of this course, the thirteenth in its series, is to provide an annual updating of the most useful recent advances in the diagnosis and management of internal medical disorders as they are encountered by primary care physicians and practicing specialists.

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HIGHLIGHTS

State of the Art Lectures

Each subspecialty will be introduced by a State of the Art Lecture given by a distinguished authority.

Meet the Faculty Sessions

These sessions will consist of simultaneous small meetings in which illustrated aspects of each subspecialty will be presented followed by open discussions of topics not formally reviewed in the lectures.

Ladies Activities

An extensive program will be offered.

Learning Center

The Learning Center consists of fully automatic synchronized cassette/slide projection of lectures. This center will be available during the evenings.

Audio Visual Aids

Audio visual teaching aids (television sets with tape players, slide projectors synchronized with cassette tapes and guides) will be available during the entire meeting for self instruction and reinforcement.

Exhibits

Scientific and Technical Exhibits will be shown daily.

SUPERVISED CME ACTIVITIES: 35 Hours Credit

As an organization accredited for continuing medical education, the University of Miami School of Medicine certifies that this continuing medical education offering meets the criteria for 35 credit hours in Category I of the Physician's Recognition Award of the American Medical Association, provided it is used and completed as designed. Approval by the American Academy of Family Physicians for prescribed hours will be applied for.

SELF-INSTRUCTIONAL MATERIALS: 25 Hours Credit

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Registration: \$350—Physicians \$200*—Physicians in training

*Letter from Chief of Service must accompany registration.

For Registration and Information write to: J. Bocles, M.D., Department of Medicine, University of Miami School of Medicine, P.O. Box 520875, Miami, Florida 33152. Phone: (305) 547-6063.



25th Anniversary of the University of Miami School of Medicine

E. M. Papper, M.D.

On September 22nd, 1952, the University of Miami School of Medicine opened the doors of a pseudo-Spanish style building, which had been completed in 1926 to serve as the sleeping quarters for the domestic staff of the Biltmore Hotel in Coral Gables, to 28 medical students. The entering class, which consisted of 26 males and two females, was limited only to Florida residents. To be considered a Florida resident, the selected applicant and his family had to have lived in the State of Florida for at least seven years. Those were the provisions of the legislative bill which committed the State of Florida to subsidize the first accredited and approved medical school established in this State. The School of Medicine remains fully committed to Florida residents with well over 95% of our present undergraduate student body of 615 coming from within the State.

Many were skeptical that the new School of Medicine would still exist by 1956 at which time it would graduate its first class and become accredited. It was said that no School of Medicine would survive in the swamps of the Everglades, and that the University of Miami, which was just emerging on its own, could not support a professional school from the meager resources available.

In October of 1976, the Editors of the Journal of the Florida Medical Association recognized the 50th

Anniversary of the University of Miami and the 20th class to receive the Doctor of Medicine degree from the School of Medicine, by dedicating a special issue to the School of Medicine. The October Journal contained an historical perspective of our young institution, a profile of the School's considerable accomplishments in education, research and patient services, as well as a description of our progress with the Public Health Trust of Dade County in developing a great Medical Center.

On the evening of November 12, 1977, we will officially celebrate the 25th birthday of the University of Miami School of Medicine at a dinner at Omni in Miami. The purpose of the celebration is to publicly express our gratitude to the many groups and individuals who have contributed to the consistent growth of this excellent School of Medicine. We hope that many of our colleagues in the Florida Medical Association, their friends and families will wish to join us that night.

First and foremost, we recognize the Florida Legislature which gave us our birthright and the initial financial support necessary to establish the first accredited medical school in Florida. The authorizing Act, which started as Senate Bill No. 71, was signed into law by the Governor on March 29, 1951, and states:

"AN ACT Relating to Medical School Education in the State of Florida; Authorizing the Board of Control to Pay to the First Approved and Accredited Medical School Established in Florida the Sum of Three

Dr. Papper is Vice President for Medical Affairs and Dean, University of Miami School of Medicine, Miami.

Thousand Dollars per Year for Each Qualified Florida Student Enrolled; Defining the Necessary Qualifications of a Medical School and Medical Students to Receive Benefits; Regulating the Expenditure of Such Funds by Said School; Limiting the Number of Students from Each County and Providing Appropriations to the Board of Control. . . ."

We are extremely grateful for the support that has been provided, and will be provided in the future. It has served as the fulcrum for the structure and development of our young School of Medicine.

Dade County has made a substantial contribution to the School by allowing us to use Jackson Memorial as our primary teaching hospital. The County also provided desperately needed land in the Medical Center at token cost, as well as nearly \$2 million in matching funds for the construction of the Medical Research Building. During the first 25 years, the mutual goals of the Hospital and the Medical School grew and strengthened. Since the creation of the Public Health Trust, the relationship has become warm and close and one of the truly great Medical Centers in the Southeastern United States has taken shape. More important, there is now a partnership dedicated to providing an atmosphere of excellence in patient care, education, and research. Continued support from Dade County is essential if we are to achieve our goals in the area of patient care. The citizens of Dade County recognized the importance of improving available health care resources by their affirmative vote of the \$38.5 million Decade of Progress Bond Issue in 1972.

The Dade County Medical Association also played a major role in the establishment of our School of Medicine. In the early fifties they joined forces with President Bowman Ashe and helped establish the new School. This collaboration did not end with the initial legislation. It required judicial interpretation that the University of Miami was, in fact, eligible. During the early years many Dade County physicians served on the School's clinical faculty, providing a welcome and excellent source of creative talent. Our voluntary faculty still numbers nearly 1,000 and they make a substantial contribution to the training of the future physicians of Florida and the nation. The past decade has been characterized by even stronger relationships between the School of Medicine and the Dade County Medical Association and the Florida Medical Association.

One of the major sources of strength of our School of Medicine has been a dedicated faculty

that has remained fully committed despite a shortage of funds and inadequate facilities. From the earliest records, it was clear that the servants quarters of the Biltmore Hotel were expected to serve no more than two years. In August, 1969, 17 years after the School was opened, the Rosenstiel Medical Science Building was completed and there was, for the first time, an integrated environment to carry out the activities of the School of Medicine. In early 1970, the School was awarded a \$4 million federal grant to match private funds for the completion of the top three shell floors of the Rosenstiel Medical Science Building. The building was fully occupied in August, 1972, twenty years after the School opened. This permitted the clinical faculty to move from dilapidated County cottages and inadequate office space provided by the Hospital, into a new teaching and research setting.

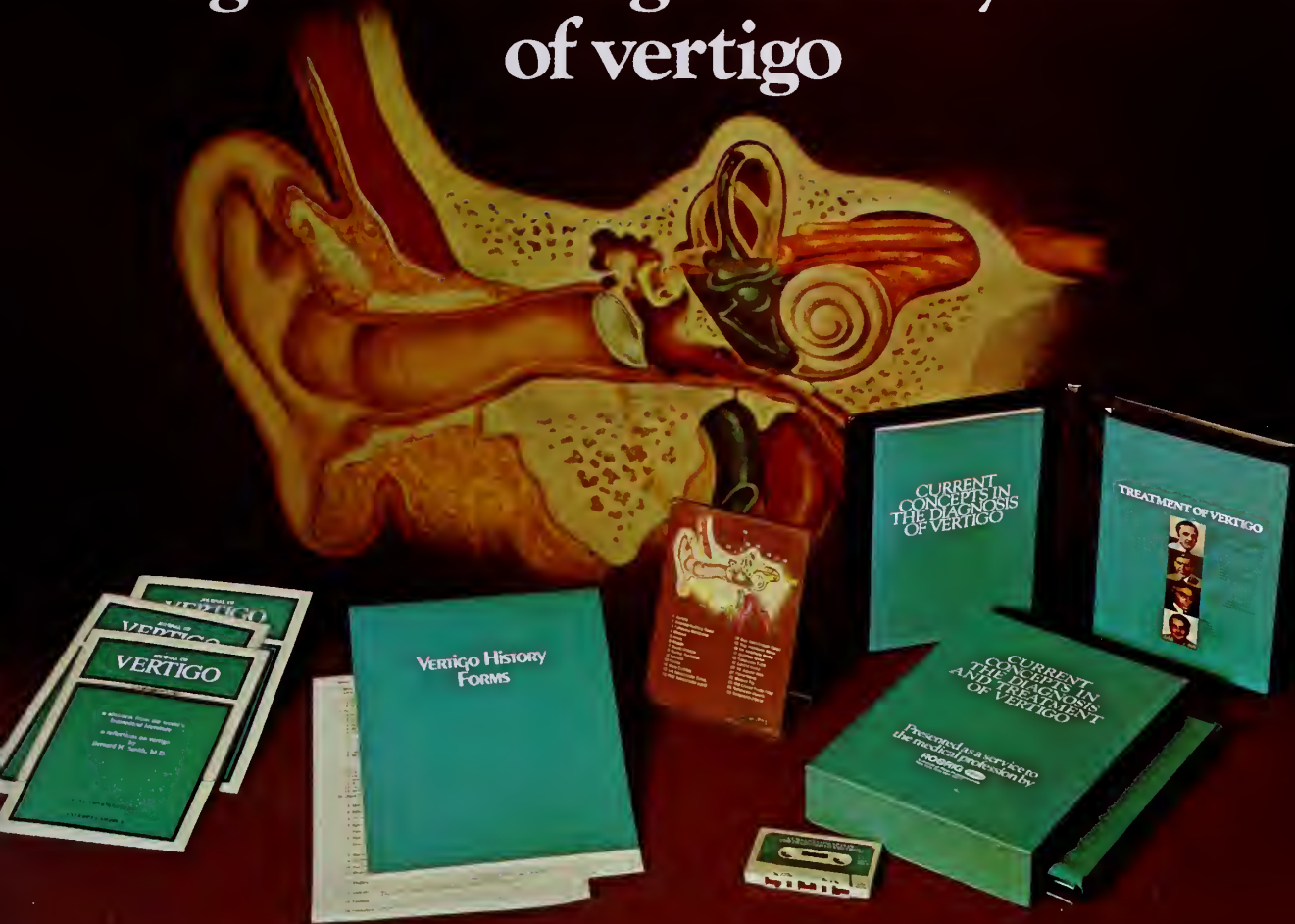
Today there are more than 600 full-time faculty members; including some of the most able and outstanding scientists, scholars and educators in the country. They are the heart of the system which has been able to build a fine Medical Center, develop solid educational programs at every level and bring the University to a place of prominence among other universities and colleges in the United States. They have, in turn, attracted a strong, highly motivated student body.

It would be impossible to recognize the numerous private groups and individuals who have directed their philanthropy to the University of Miami School of Medicine. Without their generous support we would have been unable to achieve in a relatively few years what it has taken others much longer to accomplish. We express our deep appreciation to those who have worked in our behalf in the past and those who will work with us in the future.

Finally, I wish to recognize our most important constituency; the students and alumni of the School of Medicine. This year, 615 undergraduate students were enrolled. Their qualifications are comparable to the best in the country. It is a pleasure to have the opportunity to assist them in becoming members of our noble profession. To date we have graduated 1,858 physicians. We have a remarkably close relationship with the alumni of the University of Miami School of Medicine, and we are grateful for the loyal support and the positive reflection they have made on our School and the profession.

- Dr. Papper, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152.

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Summary of the FMA Board of Governors Meeting October 4 - 9, 1977

1978 Called Meeting

Directed that there be a called meeting of the House of Delegates, February 4-5, 1978 to consider the Associations state and national legislative programs and that the format include a President's report on the Associations priorities.

Florida Health Data Corporation

Ratified the Bylaws of the Florida Health Data Corporation. The purpose of this Corporation whose membership is composed of representatives of the FMA, the Florida Hospital Association and the Florida Osteopathic Medical Association is to establish a mechanism for health data collection in the private sector. It is part of FMA's effort to establish a statewide peer review organization (PRO).

Constitutional Revision Commission

Received a report on the hearings and deliberations of the constitutional revision commission and the FMA Presidents' testimony before the commission outlining FMA's proposal for a separate Department of Health headed by a secretary of cabinet level rank.

Cost of Medical Care

Approved an outline for activities of the Association regarding the cost of medical care to include:

1. Publication of the reasons and areas for cost increases:
 - Labor Costs
 - Inflation
 - Increased utilization of services
 - Standards of first class services
2. Development of timely review of physicians charts in comparison with other physicians.

AMA Benjamin Rush Award

Nominated Dr. Luis M. Perez, Sanford, Florida to the AMA for consideration as recipient of the Benjamin Rush Award for community service by a physician.

Resolution 77-16 Waiver of Coverage

Received a report from Dr. Joseph Matthews, Chairman of Blue Shield regarding Resolution 77-16 referred to the Board of Governors by the House of Delegates and approved a report to the House at the 1978 Annual Meeting regarding Blue Shield's efforts to rectify discrepancies in its policy regarding waivers of coverage, where they exist.

Resolution 77-25 Medicare Physicians Profiles

Expressed approval of the actions taken by Blue Shield regarding Resolution 77-25 in refusing to release the names of physicians and their profiles or fees.

American Cancer Society - Resolutions on Smoking

Approved FMA support of the American Cancer Society's Resolution on smoking which encourages physicians to serve as examples by eliminating cigarette smoking.

AMA President-Elect

Expressed enthusiastic support for the candidacy of Jere W. Annis, M.D., Lakeland, Florida for President-Elect of the AMA.

1978 Budget

Reviewed the Associations financial

statement and approved the operating budget for the fiscal year January 1 - December 31, 1978.

Staff Reorganization

Received a report from the Executive Vice President regarding reorganization of the FMA staff including the opening of FMA Branch offices in Central and South Florida.

COUNCILS AND COMMITTEES

Committee on Allied Health Professions

Advanced Nurse Practitioners

Approved a high level meeting at the earliest possible date between representatives of the FMA, the Florida Nurses Association and the SBME for the purpose of seeking solutions to the present disagreements over the rules and regulations for promulgating the new Nurse Practice Act and the role of the advanced nurse practitioner.

Pharmacy

Authorized informal discussions between representatives of FMA, and the Florida Pharmaceutical Association and the University of Florida College of Pharmacy regarding proposed pharmacy programs effecting the future role of the pharmacist.

Judicial Council

Yellow Page Listings

Approved continuation of the current policy of the Association governing the listing of members in the telephone directories (white and yellow pages) as adopted by the House of Delegates.

SBME Deputization

Recommended guidelines to be used by the SBME when deputizing members of the Association for conducting investigations under the jurisdiction of the SBME.

Council on Legislation and Regulation

Clinical Laboratory

Requested the support of Florida's Congressional Delegation in eliminating the restrictive exemption for physicians' offices in pending clinical laboratory act amendments.

Certificate of Need

Placed high priority on working with the AMA in defeating pending legislation which would require certificate of need for physician's office equipment.

Florida Legislature

Reaffirmed the Association's legislative priority for:

- Establishment of a separate Department of Health
- Recovery of defense cost in medical malpractice cases.

Expressed support for legislation to bring about:

Revision of the states Medicaid program, particularly in the area of total funding,

Increased funding for the SBME to enable the Board to carry out its responsibilities including increased authority for the SBME to suspend the license of the incompetent physician to remain in effect until final adjudication.

Electroconvulsive Shock

Approved a Resolution regarding electroconvulsive shock that FMA oppose legislation which would prohibit or restrict the use of electroconvulsive shock therapy and which would make individual choice of treatment statutory.

Raw Milk

Adopted the position that there is no substantive evidence that raw milk as compared to pasteurized milk has any therapeutic value.

Council on Medical Services

TB Testing

Concurred in the recommendation of the School Health Medical Advisory Committee, that all school personnel exposed to children have a TB skin test annually; except for any known positive reactors, they in turn should have a chest x-ray performed in lieu of the skin test.

Ad Hoc Committee Committee on Nutrition

Authorized establishment of a special Ad Hoc Committee on Nutrition to study the quality of nutrition in schools and publication of an FMA position paper on food additives, dieting, and the importance of good nutrition.

Medicaid Reimbursement

Authorized discussions with the Department of HRS regarding, more efficient processing of Medicaid claims, and to insure that government fee schedules and third party reimbursements for physicians in rural areas be elevated to match those of participating physicians in urban areas.

Whooping Cough

Expressed concern over the present epidemic of whooping cough and recommended that all children be properly immunized.

Chlorination of Waters

Adopted the position that all public water supplies should be chlorinated.

FTE Funding for Athletics	Supported the concept of creation of positions for high school athletic trainers, insurance coverage for student athletes and utilization of proper athletic equipment.		the <i>Journal</i> by the Florida Magazine Association.
Ambulances at Football Games	Requested medical directors of local EMS programs to encourage ambulances be on standby at high school football games if feasible.	Continuing Medical Education	Adopted the policy that all FMA members engaged in the active practice of medicine be subject to the full requirements of the CME program and that appeals for exemptions and extensions be considered on an individual basis.
Athletic Training Grant	Authorized the Florida Medical Foundation to seek a grant from an athletic supply company for conducting a survey of high school athletic training programs, and initiating an athletic injury reporting service for Florida.	Diabetes Advisory Council	Expressed support for the work of the Florida Diabetes Advisory Council in securing funds to study the impact of diabetes mellitus in the state, the present resources for education, research and training in diabetes, and to identify needs relating to diabetes, and that the secured funds be administered through the State University Systems/Department of Education.
EMS Communications	Adopted a Resolution on EMS Communications stressing the importance of two way voice communications between a responsible physician and EMS personnel in assuring availability of an acceptable minimum level of emergency medical care throughout the state on a first priority basis.	AMA Winter Scientific Assembly	Commended Dr. J. Lee Dockery and Dr. Yank D. Coble, Jr. for their outstanding and time consuming efforts in developing the program for the 1977 AMA Winter Scientific meeting to be held at Miami Beach December 10-13, 1977.
Health Insurance Review	Approved revised operating procedures for health insurance review including an increase in the administrative fee to \$50.00 per case.	Council on Specialty Medicine	
PMUR	Authorized renewal of the Florida Medical Foundation-Blue Shield contract for peer medical utilization review for Medicare for the period, October 1, 1977 — September 30, 1978 and the contract between FMF and Group Health Insurance for Peer Review in Dade and Monroe counties for the period, July 1, 1977 - June 30, 1978.	Specialty Group Recognition	Approved the establishment of an annual recognition program for specialty groups requiring submission of an application each year including the following information: <ul style="list-style-type: none"> A. Membership roster B. Current Bylaws C. List of Officers and Council Representatives D. Summary of Continuing Medical Education Programs E. A Statement on any Planned Legislative Objectives F. Minutes of Last Annual Meeting
Bethesda Memorial Hospital	Expressed support for the Resolution adopted by the Bethesda Memorial Hospital regarding hospital inspections for legislative action to combine the annual and/or biennial inspections, investigations and surveys of the Joint Commission on Accreditation of Hospitals, the State's Department of Health and Rehabilitative Services regarding Hospital Licensure, the State Fire Marshall, the County Fire Marshall and the County Health Department.	Family Practice Residency Programs	Endorsed the concept of family practice residency programs and urged all specialty groups to participate in the training of family practice residents.
FMA Journal	Commended the Editor of the <i>FMA Journal</i> , Gerald L. Schiebler, M.D. for the general excellence of the <i>Journal</i> and for the award given to	Medicald PMUR	Received a report that a contract had been finalized between the Florida Medical Foundation and the Department of HRS, whereby the FMF agrees to provide peer medical utilization review services for Medicaid. It is expected that the contract will be executed in the immediate future.

**1978 Annual Meeting
Format**

Approved the format for the 1978 FMA Annual Meeting to be held at the Diplomat Hotel, Hollywood, Florida, May 3-7, 1978:

Wednesday, May 3 - 10:00 a.m. — General and Delegates Registration

1:00 to 4:15 p.m. — Scientific Sections

4:30 to 5:30 p.m. — First House of Delegates

Thursday, May 4 —

8:00 a.m. - Blue Shield Annual Meeting

10:00 a.m. - Reference Committees Nos. II & IV

11:00 a.m. - Reference Committee No. III

1:30 to 5:30 p.m. - Scientific Sections

Reference Committees if Necessary

Friday, May 5 —

8:00 to 10:45 a.m. - Scientific Sections & Specialty Groups

11:00 a.m. — General Session (Baldwin Lecture)

12:15 to 2:00 p.m. - Auxiliary and FLAMPAC Luncheon

2:00 to 5:30 p.m. — Scientific Sections

6:30 to 7:30 p.m. - President's Reception

7:30 p.m. - Specialty Group Socials

Saturday, May 6 —

8:00 to 12:45 p.m. - Specialty Groups & Scientific Sections

1:00 to 2:45 p.m. — Specialty Groups & Scientific Sections

3:00 p.m. - Second House of Delegates

7:30 p.m. — Specialty Group Socials

Sunday, May 7 —

9:00 a.m. — Third House of Delegates

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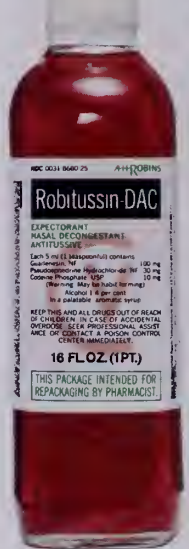
Kaolin	6.0 g.
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- Relieves congestion, reduces edema, promotes drainage.
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References

*National Disease & Therapeutic Index, Jan.-Dec., 1976. IMS America Ltd., Ambler, Pa. 1976.
†Amer. Med. Assn., Dept. of Drugs, A.M.A. Drug Evaluations, 2nd Edition, Publishing Sciences Group, Inc., Acton, Mass., 1973. pp. 482-3.

Robitussin[®] -DAC—Each 5 ml (1 teaspoonful) contains: Guaifenesin, NF 100 mg; Pseudoephedrine Hydrochloride, NF 30 mg; Codeine Phosphate, USP 10 mg (Warning: May be habit forming) in a palatable, aromatic syrup. Alcohol, 1.4 per cent. INDICATIONS: For the temporary relief of cough and nasal congestion as may occur with the common cold or with inhaled irritants. **CONTRAINDICATIONS:** For the temporary relief of any of the ingredients, marked hypertension, hyperthyroidism, or in patients who are receiving MAO inhibitors or antihypertensive medication. **WARNINGS:** Use this product with caution in children under 2 years or in children taking another drug. Prescribe cautiously for patients with persistent or chronic pulmonary disease or shortness of breath. This product should be administered with caution. As with all products containing sympathomimetic amines, use with caution in patients with high blood pressure, heart disease or diabetes. Do not exceed recommended dosage because at higher doses nervousness, dizziness or sleeplessness may occur. May cause or aggravate constipation. NOTE: Guaifenesin has been shown to produce a color interference with certain clinical laboratory determinations of 5-hydroxyindoleacetic acid (5-HIAA) and vanillylmandelic acid (VMA). **ADVERSE REACTIONS:** Agitation, dizziness, insomnia, palpitations or nausea may occur in such instances, reduction in frequency and/or quantity of dose is indicated. **RECOMMENDED DOSAGE:** Adults: 1 or 2 teaspoonfuls every 4 hours, not to exceed 12 teaspoonfuls in a 24-hour period. Children 6 to under 12 years: 1 teaspoonful every 4 hours, not to exceed 6 teaspoonfuls in a 24-hour period. Children 2 to under 6 years: 1/2 teaspoonful every 4 hours, not to exceed 3 teaspoonfuls in a 24-hour period. Children under 2 years: use is directed by a physician. **ALSO AVAILABLE:** Robitussin[®] Robitussin-CF[®] Robitussin with phenylpropanolamine and dextromethorphan Robitussin DM[®] Robitussin with dextromethorphan DM[®] Robitussin[®] Cough Calmers[®] lozenges (Robitussin PF[®] Robitussin with pseudoephedrine Robitussin A-C[®] Robitussin A H[®] Richmond, Va. 23220

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

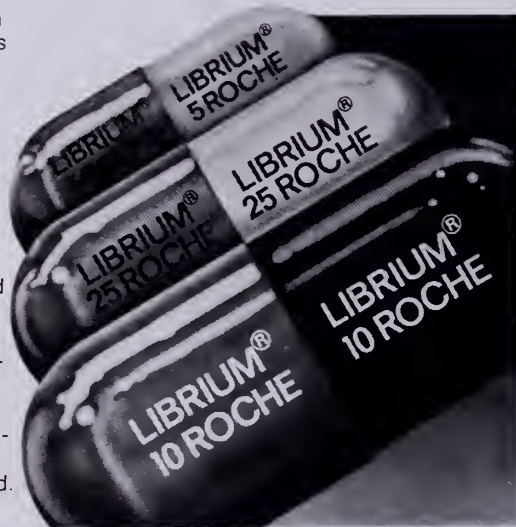
Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psycho-

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tropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relation-

ship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. **Oral—Adults** Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* **Geriatric patient** 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

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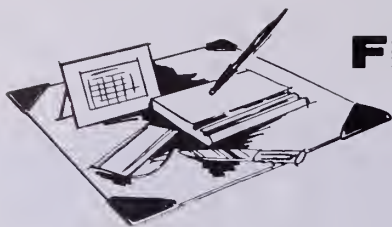
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Please see preceding page for a summary of product information.



FROM THE EDITOR'S DESK

PRACTICE MANAGEMENT

AMA is offering several types of practice management workshops for state and county medical societies during 1978. They include one-day practice and financial management programs for physicians, half-day sessions for medical office personnel on telephone management, patient relations and medical collections. Interested societies should contact the AMA Department of Practice Management for planning packets and reservation of dates.

* * * *

DOCTORS & NURSES

Case histories about physicians and nurses who have combined their talents and established joint practices are described in the new book, *Together: a Casebook of Joint Practice in Primary Care*. Copies are available at \$5.95 from NJPC/EPIC, 7383 Lincoln Ave., Chicago, Ill. 60646.

* * * *

SALINE EMESIS

The AMA is supporting a rule proposed by the Consumer Product Safety Commission that saline emesis not be included in first aid instructions on the labels of hazardous substances. The Commission's statement would suggest the use of Ipecac syrup as the appropriate emetic. In a letter to the Commission, AMA said it concurs "that the past practices of using saline emesis should not be continued or advocated."

* * * *

HEALTH CARE VS. PLEASURE

Americans spend vastly more money on pursuit of pleasure than they do on health care. An article in *The Journal of the American Medical Association* says in 1975 Americans spent \$119.75 billion on recreation, alcohol, tobacco, and personal grooming. During the same time, health care spending amounted to \$86.43 billion.

* * * *

INSURANCE ORGANIZATION

Representatives of 15 physician-owned professional liability insurance companies have decided to proceed with the organization of a national trade association. Two committees, one on organization and the other on risk management, met in Chicago in August to prepare recommendations for the group, which would be coordinated through the American Medical Assurance Company.

* * * *

COST CONTAINMENT

The Senate Finance Committee has received the Administration's hospital cost containment bill. Several changes have been made by the Human Resources Committee. As it stands, the bill gives the states a stronger voice than the Administration recommended in imposing a 10% cap on hospital revenue rate increases annually.

* * * *

HEW'S CORRECTION

At long last the Department of HEW has corrected its list of physicians and medical groups said to have billed \$100,000 or more in Medicare claims in 1975. The AMA found that the original list released last March had an error rate of 65%. The corrected list shows that 64 physicians originally named did not have billings of \$100,000; and that payments to 338 previously named physicians represented group rather than individual income.

* * * *

VIDEO VIOLENCE

A Harris Survey reveals that 71% of its sample believes there is too much murder and mayhem on television. Almost nine of every 10 interviewed believe that violence on the tube triggers violent acts in the maladjusted and unstable.

* * * *

The Editor



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(1) To help contain costs.

(2) To upgrade medical care.

This program initially identifies 28 surgical and diagnostic procedures which will not be paid routinely by Blue Shield. All pertinent claims will be reviewed for medical necessity and covered only when a clear need can be proven.

Following is a list identifying the 28 surgical and diagnostic procedures:


1. Ligation of Internal Mammary Arteries, Unilateral or Bilateral
2. Radical Hemorrhoidectomy, Whitehead Type
3. Omentopexy — Portal Obstruction
4. Kidney Decapsulation, Unilateral and Bilateral
5. Perirenal Insufflation
6. Nephropexy
7. Circumcision, Female
8. Hysterotomy
9. Supracervical Hysterectomy
10. Uterine Suspension
11. Uterine Suspension with Presacral Sympathectomy
12. Hypogastric or Presacral Neurectomy
13. Fascia Lata by Stripper — when used to treat lower back pain
14. Fascia Lata by Incision — when used to treat lower back pain
15. Ligation of Femoral Vein, Unilateral and Bilateral — when used to treat Post Phlebitic Syndrome
16. Excision of Carotid Body Tumor — when used to treat Asthma
17. Sympathectomy, Thoracolumbar, Unilateral or Bilateral — when used to treat Hypertension
18. Sympathectomy, Lumbar — when used to treat Hypertension
19. Basal Metabolic Rate — BMR
20. Protein Bound Iodine — PBI
21. Icterus Index
22. Ballistocardiogram — BCG
23. Phonocardiogram with Interpretation and Report
24. Angiocardigraphy, using Carbon Dioxide, Supervision and Interpretation Only
25. Angiocardigraphy, Single Plane, Supervision and Interpretation Only, in Conjunction with Cineradiography
26. Angiocardigraphy, Multi-Plane, Supervision and Interpretation Only, in Conjunction with Cineradiography
27. Angiography — Coronary, Unilateral, Selective Injection, Supervision and Interpretation Only, Single View unless in an Emergency
28. Angiography Extremity

This program was developed in cooperation with The American College of Physicians, The American College of Surgeons and The American College of Radiology. We ask your support in making our Medical Necessity Program 100% effective.*

*A claims review by The Florida Plan indicated that most of the procedures were already being screened for medical need and few of the services in question were being performed in Florida.



Blue Shield
of Florida



ORGANIZATION

FMF Announces Plans to Co-sponsor Category I CME Courses

The Florida Medical Foundation will consider applications from qualified organizations to co-sponsor continuing medical education activities for AMA Category I Credit.

According to Robert H. Threlkel, M.D., Jacksonville, county medical societies, community hospitals, FMA-recognized specialty groups, medical groups and clinics and voluntary health agencies may apply.

Dr. Threlkel is Chairman of the FMF's Committee on Medical Education, which last summer was accredited by the American Medical Association for continuing medical education. Accreditation authorizes the Committee to co-sponsor CME programs with other groups and certify them as meeting the criteria for Category I credit.

Only programs which meet the AMA's definition of "a planned program of CME" will be considered, Dr. Threlkel said.

A planned program is defined as "having sufficient scope and depth of coverage of a subject area or theme to form an educational unit and that is planned, administered and evaluated in terms of educational objectives defining a level of knowledge or a specific performance skill to be attained by the physician participating in the program."

Under AMA rules, the Committee must also be involved early enough to participate in the planning of the program, Dr. Threlkel added.

At its meeting in Tampa on September 25, the Committee agreed to co-sponsor:

—The Third Annual Course in Behavioral Neurology and Neuropsychology, December 8-10, Dutch Inn, Lake Buena

Vista. Sponsored by the Florida Society of Neurology, the course offers 15 hours of Category I Credit.

—Annual Fall Meeting of the Florida Radiological Society, October 29-30, Contemporary Hotel, Walt Disney World. 7 hours of Category I Credit.

The Committee also adopted guidelines and procedures for extending accredited co-sponsorship, and these and other materials will be mailed to potential sponsoring organizations in the near future.

Voter Registration Campaign Started by FLAMPAC

The Florida Medical Political Action Committee (FLAMPAC) is in the midst of a drive to get all physicians registered to vote in next year's elections.

FLAMPAC President John W. Glotfelty, M.D., Lakeland, said presidents of county medical societies, specialty groups and local Auxiliary units are being asked to contact physicians and encourage them, their office staffs and their families to register. The drive began in October and will continue through November.

It is estimated that in some counties as many as 20 per cent of the physicians are unregistered.

CARDIAC ARRHYTHMIAS

January 6, 7, 8, 1978

Omni International Hotel, Miami, Florida

Program Director — Dr. Ralph Lazzara

Co-Directors — Dr. Benjamin Befeler
and Dr. Benjamin Scherlag

COURSE DESCRIPTION

This course will be oriented toward cardiologists and generalists dealing with cardiac arrhythmias. It will include topical coverage of mechanisms, diagnosis, and management of arrhythmias in ischemic heart disease, pre-excitation syndromes, and other disease categories.

GUEST FACULTY

Dr. J. Thomas Bigger, Jr., Professor of Medicine and of Pharmacology, College of Physicians and Surgeons of Columbia University, New York, NY.

Dr. John A. Kastor, Professor of Medicine Hospital of the University of Pennsylvania, Philadelphia, PA.

Dr. Kenneth M. Rosen, Professor of Medicine, Abraham Lincoln School of Medicine, University of Illinois, Chicago, IL.

ACCREDITATION

This Continuing Medical Education offering meets the criteria for 16 hours of credit in Category I for the Physician's Recognition Award of the American Medical Association. Approval by the American Academy of Family Practice — 16 prescribed hours.

GENERAL INFORMATION

Registration Fee:

\$200 — Non-members, Council on Clinical Cardiology.

\$175 — Fellows and Members of the Council on Clinical Cardiology* and Physicians in Training.

NOTE: *Membership card for the Council on Clinical Cardiology must accompany registration and will be returned with registration confirmation.

Checks should be made payable: "U/MIAMI CARDIAC ARRHYTHMIAS". A refund will be made only if cancellation is postmarked no later than December 15, 1977.

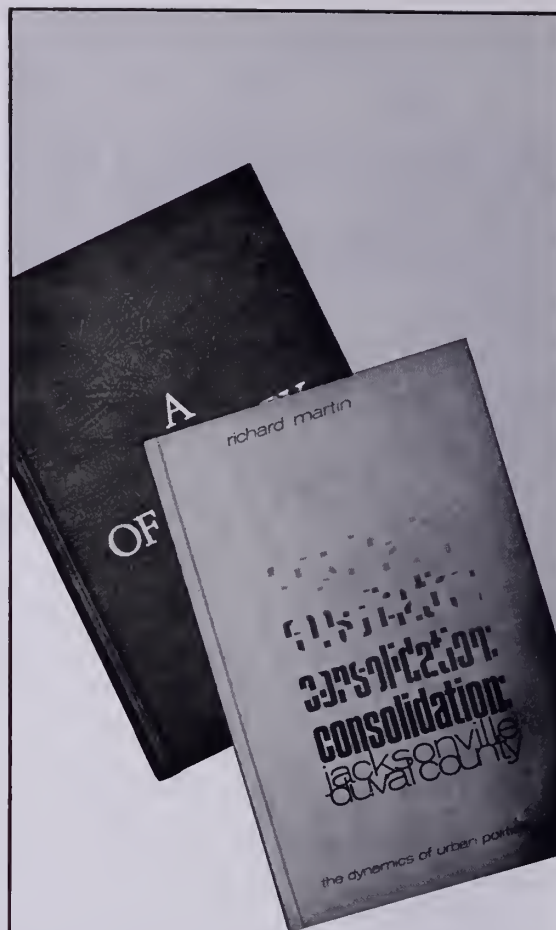
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Department of Medicine — Section of Neurology

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College of Medicine

Melvin Greer, M.D.
Professor and Chairman
Department of Neurology
University of Florida
College of Medicine

Calvin Hudson, M.D.
Clinical Associate Professor
Division of Neurosurgery
Department of Surgery
JHEP/University of Florida
College of Medicine

Oscar M. Reinmuth, M.D.
Professor and Chairman
Department of Neurology
Univ. of Pittsburgh
School of Medicine

Jacob Green, M.D.
Clinical Associate Professor
Department of Neurology
JHEP/University of Florida
College of Medicine

Edward L. Hogan, M.D.
Professor & Chairman
Department of Neurology
Medical University of
South Carolina

Leon D. Prockop, M.D.
Professor and Chairman
Department of Neurology
Univ. of South Florida
College of Medicine

Robert R. Young, M.D.
Assoc. Professor of Neurology
Dir. of Clinical Neuro-Physio Lab.
Massachusetts General Hospital

SATURDAY MORNING, Schultz Auditorium

10:00 - Past, Present & Future of **"Evoked Visual,
11:00 a.m. Auditory & Sensory Potentials"**

SATURDAY AFTERNOON — Schultz Auditorium

12:30 p.m. Registration
1:30 p.m. **"The Current State of Electromyography"**
— Robert Young, M.D.
2:00 p.m. **"Head Injury & EEG"**
— Frederick Gibbs, M.D.
3:00 p.m. Coffee Break
3:15 p.m. **"The Diagnosis & Treatment of Multiple Sclerosis"**
— Edward L. Hogan, M.D.
4:00 p.m. Panel Discussion with Drs. Gibbs, Hogan & Young
Moderator: Jacob Green, M.D., Program Chairman
4:30 p.m. Adjourn

SUNDAY MORNING — Schultz Auditorium

9:00 a.m. **"Update on Stroke Therapy, the Use of Steroids
In Stroke Patients"**
— Oscar Reinmuth, M.D.
9:45 Coffee Break
10:00 a.m. **"The Current Management of Headaches"**
— Melvin Greer, M.D.
10:45 a.m. **"The Work-Up and Treatment of the Patient with
Neuropathy"**
— Leon D. Prockop, M.D.
11:30 a.m. **"Dorsal Column Stimulation in Multiple Sclerosis
Patients"**
— Calvin Hudson, M.D.
12:15 p.m. Panel Discussion with Drs. Greer, Hudson,
Prockop and Reinmuth
12:45 p.m. Adjourn

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Thomas E. Wheeler, Ph.D., Vickie M. Neisen, Ph.D.,
 Barkley Beldleman, M.D., and Kyran Dowling, B.A.

ABSTRACT: A cation exchange column was used to fractionate the hemoglobin of 20 diabetic patients, 50 normal controls and five patients with sickle cell trait. The level of hemoglobin A_{1c}, or the total fast fractions (hemoglobins A_{1a} + A_{1b} + A_{1c}), reflects the clinical evaluation of overall carbohydrate control and may be a more informative blood component to monitor in diabetics than fasting serum glucose. The established normal range for hemoglobin A_{1c} of $4.4 \pm 1.2\%$ of total hemoglobin A (mean ± 2 S.D.) is not applicable to patients with sickle cell trait. In the presence of hemoglobin S, there appears to be an increased level of synthesis of hemoglobin A_{1c}. The chromatographic migration of hemoglobin S is also described.

An increasing number of articles associated with the methodology and clinical significance of minor hemoglobin components are appearing in the literature. Those hemoglobins which move most rapidly on a weak cation exchange column in a cyanide-phosphate buffer at pH 6.70 are referred to as the fast fractions and include hemoglobins designated A_{1a}, A_{1b} and A_{1c}. Hemoglobin A_{1c}, a glycoprotein, as well as the total of A_{1a}, A_{1b} and A_{1c} has been correlated with glucose metabolism.^{1,2} There is strong evidence to indicate that either A_{1c}

alone or the sum of the fast fractions may reflect the clinical status of diabetes with greater validity than serum glucose levels. Since A_{1c} is not as readily subject to rapid changes as glucose, it is probably a more consistent blood component to measure in determining how well a patient is following his therapeutic regimen and the extent of his stabilization.

To determine the efficacy of hemoglobin A_{1c} quantitation in monitoring the clinical status of diabetes, hemoglobin fractionations were performed for patients being followed monthly in a diabetic clinic. One normal control was drawn in each group of six subjects and submitted without status identification. During the course of this study and the concomitant normal study, several subjects with sickle cell trait were discovered. Observations on hemoglobin S as well as the results for normal and diabetic subjects are presented.

Materials and Methods

Hemoglobin Preparation: Blood samples were drawn using EDTA as anticoagulant. The red cells were washed, hemolyzed and the hemolysate dialyzed by the method of Clegg and Schroeder.³

Column Chromatography: Twenty-five to 35 mg of total hemoglobin were applied to 5 cm³ of Bio-Rex 70 resin (200-400 mesh, Bio-Rad Laboratories) in 1 x 19 cm chromatography columns (New England Nuclear). Hemoglobin separation was by the method of Trivelli et al.¹

From Regional Medical Laboratories, Inc., and The Medical Center Clinic, Pensacola.

Two ml fractions were collected beginning with the application of the hemoglobin sample. Hemoglobins A_{1a} and A_{1b} co-eluted in the second and third fractions with the first buffer (phosphate-cyanide buffer, pH 6.70). Hemoglobin A_{1c} usually eluted in fractions 5 to 9. If A_{1a}, A_{1b} and A_{1c} were abnormally elevated, additional fractions were required to elute them. Three fractions were collected after all of the A_{1c} had been eluted before changing to the second buffer (phosphate buffer, pH 6.42). Fractions were collected with the second buffer until all hemoglobin had been cleared from the column.

Hemoglobins A_{1d} and A_{1e} were not eluted with the phosphate-cyanide buffer, pH 6.70, before changing to phosphate buffer, pH 6.42. A considerably longer elution time is required to isolate them, and since no clinical significance has been delineated for them, they were collected with the major hemoglobin fraction (A₁₁).

The hemoglobin concentration in each fraction was determined from absorbance at 541 nm.⁴

Electrophoresis: Hemoglobins were separated electrophoretically on cellulose acetate with Tris-EDTA-glycine buffer, pH 9.2 (Gelman Instrument Co.).

Glucose: Serum glucose levels were determined with a SMAC (Technicon Instruments Corp.)

Subjects

Nondiabetic: Patients reporting for blood work in a fasting state, who were not and had never been on diabetic therapy and whose serum glucose levels were between 70 and 110 mg/dl.

Diabetic: Patients seen monthly at a diabetes clinic, who were at varying stages of carbohydrate control and had fasting serum glucose levels from 90 to 400 mg/dl.

Results

The hemoglobin from 50 nondiabetic subjects was chromatographed. The hemoglobin A_{1c} ranged from 3.1 to 5.8% of the total hemoglobin eluted from the columns (Fig. 1). The combined fast fractions (A_{1a}, A_{1b} and A_{1c}) ranged from 4.3 to 8.9% of the total (Fig. 2). The mean \pm standard deviation of hemoglobin A_{1c} in these normal subjects was $4.4 \pm 0.6\%$. The mean value for hemoglobin A_{1a + b} was $1.8 \pm 0.3\%$ and the mean for the combined fast fractions was $6.3 \pm 0.9\%$.

In a series of 20 diabetic patients at various stages of control, the A_{1c} fraction ranged from 4.0 to 21.2% of the total hemoglobin (Table 1). The total fast fractions (combined A_{1a}, A_{1b} and A_{1c}) ranged from 5.7 to 24.4% of the total.

Of the 20 diabetics (Table 1), two (#4 and #20) had hemoglobin A_{1c} levels falling within our established normal range of 3.2 to 5.6% (mean \pm 2 S.D.). Both of these patients were clinically stable and had serum glucose levels consistently falling within satisfactory limits.

Patients #6, #8, #12 and #19 had slightly elevated A_{1c} levels (5.7 to 5.8%). All of these except #6 were clinically well controlled and had acceptable serum glucose levels. Patients #5 and #10 are especially interesting. On the day they were drawn for A_{1c} determinations, their serum glucose levels were satisfactory. However, a month previously they both had severely elevated glucose levels. Their A_{1c} levels were also significantly elevated, confirming clinical impressions of poor overall control. Conversely, patient #15 had an elevated serum glucose on the day the sample for A_{1c} determination was drawn but had a normal serum glucose level the previous month. This patient had gained weight since the last clinic visit and the elevated A_{1c} reflects poor overall control. Patient #17 is an alcoholic and diabetic. On the day of the clinic visit, serum glucose was satisfactory, but the elevated A_{1c} as well as previous clinical impressions indicates that between visits and when drinking this patient's diabetes is out of control.

In the course of the diabetic study, one patient, #16, was found to have a second slow band of hemoglobin eluting from the column after A₁₁ and comprising 23% of the total hemoglobin. Hemoglobin electrophoresis indicated the presence of hemoglobin S. Subsequently two other diabetic patients with sickle cell trait and two subjects with normal fasting serum glucose levels and sickle cell trait were drawn for hemoglobin electrophoresis and column chromatography. The slowest hemoglobin band from the columns contained 23-29% of the total hemoglobin which agreed with 5% with the percentage of hemoglobin S determined electrophoretically. The results of the column separation are presented in Table 2. From this limited series of subjects with sickle cell trait, it appears that the established normal range for Hb A_{1c} and total fast fractions of hemoglobin are not applicable to patients with sickle cell trait.

The behavior of hemoglobin S on the chromatography column is unique. With the first buffer (phosphate-cyanide, pH 6.70), this

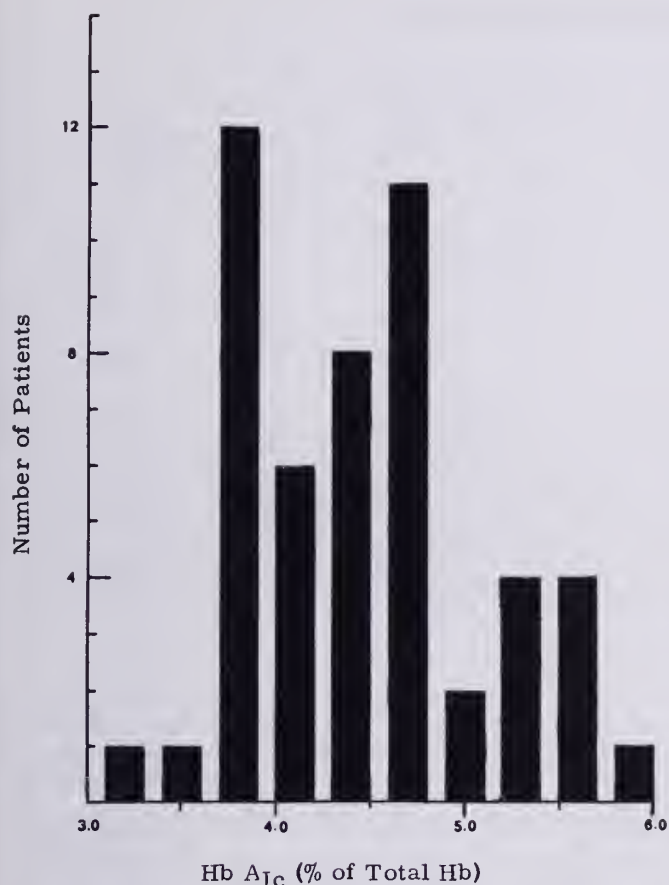


FIG. 1.—Hemoglobin A_{1c} as a percentage of total hemoglobin in nondiabetic subjects with fasting serum glucose concentrations of 70 to 110 mg/dl.

hemoglobin migrates farther than the A₁₁ band. After changing to the second buffer (phosphate, pH 6.42), hemoglobin A₁₁ migrates through the band of hemoglobin S and elutes first. Hemoglobin S elutes in an additional 10 to 15 fractions. The migration speed of hemoglobin S is minimally affected by the change in buffer pH and ionic strength suggesting it may be more contingent on molecular configuration than net charge.

Discussion

Diabetes mellitus is one of the major health problems in the United States. Despite the high incidence of this disease and the severity of its complications, no precise laboratory methods have been devised for diagnosing diabetes or for periodically monitoring carbohydrate control in diabetic patients so that complications may be reduced. Fasting glucose measurements and

glucose tolerances are sometimes difficult to interpret. Serum glucose levels are very transitory and may not reflect long-term carbohydrate equilibrium unless multiple determinations are done. Glucose tolerances do not provide an adequate distinction between diabetic and normal patients in the borderline zone and may produce variable results for the same patient due to factors such as diet, exercise and stress.

Hemoglobin A_{1c} contains neutral sugars attached to the N-termini of hemoglobin A₁₁ beta-chains.⁵ Its quantitation is a potentially valuable laboratory tool in the diagnosis and treatment of diabetes. Hemoglobin A_{1c}, as well as the total fast fractions from column chromatography (A_{1a}, A_{1b} and A_{1c}), reflects the carbohydrate status of the patient over the past weeks or months.² The elevation of hemoglobin A_{1c} and total fast fractions in uncontrolled diabetes is substantial and if the measurement of these hemoglobin components can be simplified it should become a useful laboratory aid in diabetic screening, diagnosing borderline diabetics, and evaluating diabetic treatment regimens.

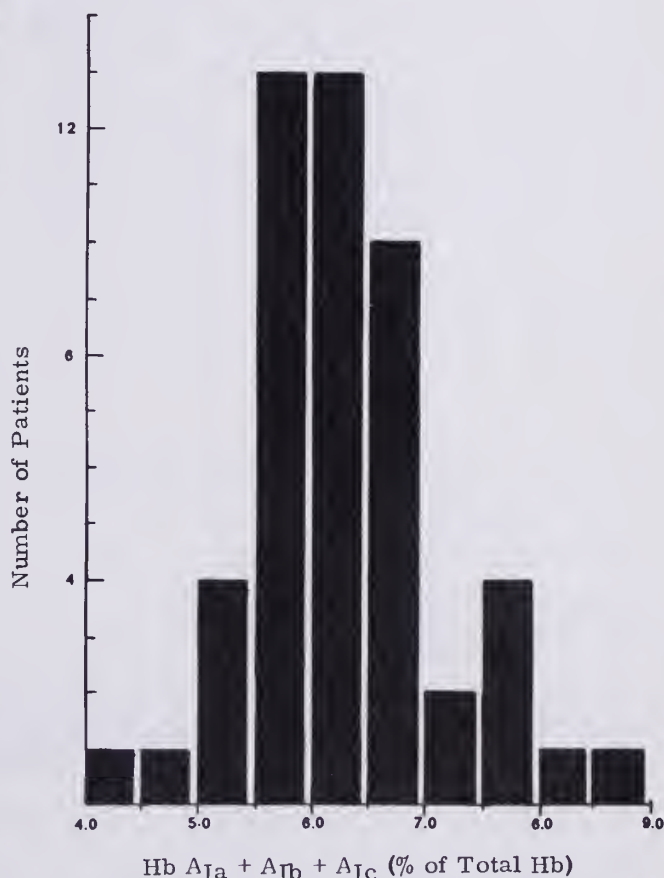


FIG. 2.—Total fast fractions of hemoglobin (Hb A_{1a} + A_{1b} + A_{1c}) as a percentage of total hemoglobin in nondiabetic subjects with fasting serum glucose concentrations of 70 to 110 mg/dl.

Table 1.—Hemoglobin Fractionation Results and Serum Glucose Levels for Diabetic Patients.¹

Patient	Hb A _{1c} ² (% of Total Hb)	Hb A _{1a} +A _{1b} +A _{1c} ³ (% of Total Hb)	Fasting Serum Glucose ⁴ (mg/dl)	Treatment Regimen
1	8.8	10.8	300	Insulin
2	7.1	9.4	204-234	Oral agents
3	7.0	9.8	190-270	Oral agents
4	4.0	5.7	150	Oral agents
5	9.5	12.0	110,300	Oral agents
6	5.8	8.1	200	Insulin
7	13.2	16.6	200	Insulin
8	5.7	7.5	135-170	Insulin
9	6.1	8.8	250-350	Oral agents
10	8.3	10.8	162,288	Oral agents
11	21.2	24.4	210-250	Insulin
12	5.7	8.2	106	Insulin
13	6.1	9.4	160	Insulin
14	11.4	14.9	185-210	Insulin
15	10.2	13.2	190, 114	Diet Alone
16	9.4 ⁵	12.7 ⁶	200-400	Oral agents
17	6.9	9.8	146-176	Insulin
18	7.3	10.7	190-210	Insulin
19	5.8	8.1	90-120	Insulin
20	4.9	7.2	120-135	Oral agents

¹ See text for clinical impressions of carbohydrate control

² $\frac{\text{mg Hb A}_{1c} \text{ eluted from column}}{\text{total mg Hb eluted from column}} \times 100$

³ $\frac{\text{mg Hb A}_{1a} + \text{A}_{1b} + \text{A}_{1c} \text{ eluted from column}}{\text{total mg Hb eluted from column}} \times 100$

⁴ If listed as a range, the patient's glucose level varies from month to month within that range. If listed as a single value, the patient's serum glucose is stable around that value. If listed as two distinct values, the first one is the glucose level on the day drawn for hemoglobin fractionation and the second one is the glucose level the previous month.

⁵ $\frac{\text{mg Hb A}_{1c} \text{ eluted from column}}{\text{total mg Hb eluted from column} - \text{mg Hb S}} \times 100$

⁶ $\frac{\text{Hb A}_{1a} + \text{A}_{1b} + \text{A}_{1c} \text{ eluted from column}}{\text{total mg Hb eluted from column} - \text{mg Hb S}} \times 100$

Table 2.—Hemoglobin Fractionation Results for Subjects with Sickie Cell Trait.

Subject	Hb S ¹ (% of Total Hb)	Hb A _{1c} ² (% of Total Hb A)	Hb A _{1a} +A _{1b} +A _{1c} ³ (% of Total Hb A)
Diabetic 1 (patient #16 from Table 1)	23	9.4	12.7
Diabetic 2	26	8.9	12.2
Diabetic 3	29	10.9	14.4
Normoglycemic 1	27	7.3	11.5
Normoglycemic 2	27	6.5	9.8

¹ $\frac{\text{mg Hb in slowest band eluted from column}}{\text{total mg Hb eluted from column}} \times 100$

² $\frac{\text{mg Hb A}_{1c} \text{ eluted from column}}{\text{total mg Hb eluted from column} - \text{mg Hb S}} \times 100$

³ $\frac{\text{mg Hb A}_{1a} + \text{A}_{1b} + \text{A}_{1c} \text{ eluted from column}}{\text{total mg Hb eluted from column} - \text{mg Hb S}} \times 100$

In normoglycemic patients with sickle cell trait, the fast hemoglobin fractions expressed as percentages of total hemoglobin A are higher than the normal ranges established for subjects without sickle cell trait. These results suggest that the presence of sickle hemoglobin causes an increased modification of hemoglobin A₁₁ to form hemoglobins A_{1a}, A_{1b} and A_{1c}. An alternative possibility is that carbohydrate-modified hemoglobin S co-elutes with modified A₁₁; however, this is unlikely considering the tremendous difference between the migration characteristics of hemoglobins A₁₁ and S. In any case, routine A_{1c} determinations on patients with sickle cell trait may give abnormal results unless a separate normal range is established.

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The most beautiful experience we can have is the mysterious. It is the fundamental emotion which stands at the cradle of true art and true science. — Albert Einstein

Effect of Transport on Recovery of *Neisseria Gonococcus*

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and Richard W. Dodd, M.D.

ABSTRACT: Culture results for *Neisseria gonococcus* processed locally were compared with those sent by mail to a distant laboratory. One hundred females were tested. Two simultaneously collected specimens from the cervix were obtained and plated on Transgrow media. One was sent to a distant laboratory and the other was grown locally. Forty-five specimens were found to be positive and of the 45, 98% were positive by local laboratory results while only 24.4% were positive by distant laboratory results. The marked discrepancy suggests the need for further evaluation of this commonly practiced procedure of sending material through the mail for culture.

There have been several studies indicating the survival of *Neisseria gonorrhoeae* organism when shipped through the mail with the use of Transgrow media.¹ It has been advocated that the media be incubated for 12 to 18 hours before mailing and that the bottles be shipped in sealed containers, such as urethane, to maintain the viability of the organisms.²

Most studies indicate an incidence of unsuspected gonorrhea in females from 0.5 to 8% depending on the population studied.^{3,9} These studies were carried out where laboratory facilities were immediately available. Literature on studies in which material has been transported via mail has been prospective and under rigid control. No study could be found which evaluated an established, functioning system which used Transgrow as the transport media for mailing specimens to a distant laboratory.

The purpose of our study was to compare the effects of transporting GC through the mail in an

already existing program, without the rigid control used in prospective studies. We selected the Volusia County Health Department in Daytona Beach, Florida, which presently is using such a system. Their procedure is as follows: Using a sterile, dry cotton applicator, a specimen is collected from the cervical os and immediately plated on a Transgrow slant bottle, as recommended by the Center for Disease Control. The bottle is held upright to ensure no loss of CO₂ and recapped immediately after plating, then placed in the incubator for 12 to 18 hours. It is then shipped via first class mail to the State Public Health Laboratory in Jacksonville, Florida. Specimens collected Friday are mailed that afternoon (no bottles are held over the weekend). Special urethane containers are not used.

Methods and Materials

After interview and screening, 100 female patients were selected from the Venereal Disease Clinic of the Volusia County Health Department (February-April 1974). The procedure for each patient was the usual one for suspected venereal disease, but on pelvic examination two dry sterile cotton swabs were inserted into the cervical os simultaneously and the specimens plated on two separate Transgrow bottles (Biomedical Products Corp.), using a single swab on each. Both bottles were matched with the same log number and expiration date, one bottle arbitrarily marked to be sent to the State Public Health Laboratory in Jacksonville, the other marked to be sent to Halifax Hospital Medical Center. Both bottles then were placed in the incubator at 35.5 C. The bottle for local culture was hand-carried to the Hospital laboratory at the end of the same day; the bottle marked for Jacksonville was mailed the following morning.

The State Public Health Laboratory and the Halifax Hospital Medical Center Laboratory used the presumptive criteria for identification of *N. gonorrhoeae*: characteristic colony morphology

Dr. Schwarz is Director of the Family Practice Center and Dr. Dodd is Director of the Family Practice Program at Halifax Hospital Medical Center in Daytona Beach. This study was funded in part by grant #1-D15-P.E. 00270001 HEW, NIH, Bethesda, Md.

oxidates positive reaction in gram stained and gram negative diplococci configuration of gram stains.

Results

As can be seen in Table 1, a total of 55 females were positive in at least one of the cultures. Forty four (98%) of the ones done locally were positive, and 11 (24.4%) of the ones sent to the State Laboratory in Jacksonville were positive.

Table 1.—Comparison of Number of Positive GC Cultures Reported by State and Local Laboratories on 100 Identical Specimens.

Laboratory	State	Local
Both State and Local	10	10
State or Local, each	1	34
TOTAL	11	44

Discussion

A significant difference in results was found between those reported by the local laboratory and the state laboratory. The implications are significant in medical, legal, epidemiological, financial, and other areas, and further investigation is needed. Although the principles in well-controlled studies have shown this to be a reliable means of transport, we cannot help but wonder if in reality this is a practical system. Meticulous care of specimens and procedures often are neglected for expediency and are not followed in such a rigid manner on a day-to-day basis.

A brief investigation was carried out and many minor factors were isolated and corrected during the study. These included checking and recording incubator temperatures twice daily, insuring that specimens were mailed on time and securely wrapped, the proper handling of the Transgrow bottle during inoculation and its immediate placement into the incubator. In addition, at the time of transport each package was marked, stating the number of hours it had been incubated, since we had learned that the state laboratory did not check specimens on arrival but rather incubated them from 24-48 hours before examining them. Withal, there was no appreciable change in results.

Conclusion

This investigation reveals that the system used at the Volusia County Health Department in identifying *Neisseria gonococcus* at the time of this study was unreliable. Corrective measures to obtain reliable results could not be isolated, although it was felt that special containers, as have been advocated in other articles, for use in the shipment of this material might help the results.

It is believed by the investigator that this probably is more widespread than is presently recognized. We certainly would advocate that similar broader based studies be initiated throughout the state to determine whether or not this problem is as widely diffused as we feel it must be.

We are indebted to the Volusia County Public Health Department for its cooperation and assistance, and especially to Mrs. Ann Walker for her personal assistance in this investigation. We wish to thank the Pathology Department of the Halifax Hospital Medical Center for providing personnel, time and material for this study.

Addendum: Since this study was performed, we have learned that the Public Health Department has made significant changes in terms of the transport media used during shipping. There has been no change in the use of special containers for shipping, however, the Department has established a system of reporting back a percentage yield of positive to local health departments in the various communities. Its purpose is to indicate trends in yields of GC cultures which may be indicative of some problem in terms of handling, processing, or material used. We feel that this is a positive step. However, since the new system remains untested we plan to repeat our study in the near future.

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SPECIAL ARTICLE

South Florida Hospital Consortium For Infection Control

N. Joel Ehrenkranz, M.D.

The series of papers presented at the annual meeting of the American Public Health Association last fall is of interest to those concerned with assessing and improving the delivery of health care in hospitals. These papers reviewed the history and activities of the South Florida Hospital Consortium for Infection Control (SFHCIC),¹ and compared clean surgical wound infection rates,² lower respiratory infections occurring in intensive care units (ICU),³ and patterns and costs of unnecessary single patient isolation⁴ in participating hospitals.

SFHCIC currently consists of 13 community hospitals in Dade, Broward, and Palm Beach counties: American, Baptist, Boca Raton Community, Biscayne Medical Center, Cedars of Lebanon, Doctors', Good Samaritan, Memorial, Mercy, Miami Heart Institute, South Miami, St. Francis and St. Mary's. These hospitals represent an aggregate of more than 4,000 beds. Each has at least one intensive care unit (ICU), nine have obstetric and newborn services, seven have major cardiac surgery programs and five have chronic renal dialysis activities — all of which reflect a multitude of patients susceptible to infection. In terms of good patient care, each hospital serves as a community leader in efforts directed at reduction of hospital-acquired infection.

SFHCIC was formed in 1971 with support from the Florida Regional Medical Program coming in 1972; the impetus was the concern of the staffs of eight hospitals to meet or improve the community standard for infection control. Although grant funding ceased in 1975, SFHCIC continues to function — in an expanded capacity — with financial support now entirely borne by the participating hospitals.

The first step was to define an acceptable standard of infection. At the outset, frequencies of pneumonia and bacteremia were determined in relation to host susceptibility factors and usage of various types of therapeutic equipment. Now, attention is being paid to wound infection in surgical procedures since the Florida hospital licensure act requires such information. Measurement of rates of surgical wound infection is based on prospective surveillance carried out by mature, motivated and highly skilled infection control nurses. The use of common criteria of wound infection, diagnostic review by knowledgeable physicians and twice monthly educational sessions insure that the observations reported by the infection control nurses are reliable and reproducible.

To develop a means for valid comparisons, surgical procedures prospectively surveyed by the infection control nurses were tabulated to determine which were frequent, generally common and permitted postoperative stay of at least four to five days for purposes of observation of possible wound infection. After a year's study it was found that a relatively few "clean" procedures accounted for half the surveyed operations and the wound infection incidence was low — 1.5% \pm .5%. This group serves as a common denominator and is called "designated operations." Included are vertebral laminectomy, herniorrhaphy, femoropopliteal bypass, mastectomy, hip arthroplasty, hip fracture repair, caesarian section without ruptured membranes and abdominal hysterectomy. This last procedure is more properly classified as "clean — contaminated" but in our experience carries a sufficiently low expected rate of infection to be included with "clean" cases in the designated group. Monthly reports of the incidence of infection in this group of operations permits current comparisons of each hospital with others in

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SFHCIC as well as comparisons with past performance. These results are regularly examined for "clusters" of infection to seek out obvious problems; quarterly, simple statistical analysis are done for the identification of less obvious problems. A simple mean rate and standard deviation (SD) are calculated. The concurrent mean rate of infection plus up to one SD defines the upper boundary of the acceptable rate of infection. Thus, SFHCIC hospitals know in a meaningful way where they stand in relation to their peers. When a hospital's rate of infection is outside the standard, the infection committee is promptly made aware of the fact. Information from all hospital sources is gathered and verified. A single type of procedure, e.g., mastectomy or herniorrhaphy, may be the source of the difficulty. If the hospital staff cannot solve the problem, help is sought from other SFHCIC members or outside experts. Such matters are private and confidential; the SFHCIC-hospital relation parallels the physician-patient relation in this regard.

A theoretical example is the following: During one quarter one hospital's rate of infection for designated operations may be 3.5% whereas the SFHCIC mean rate plus 1 SD is 2.7%. In this quarter, at least 30 laminectomies were done in each of eight SFHCIC hospitals with no or only one infection, whereas at a ninth hospital there were six infections in 30 laminectomies. Such information initiates intensive review by the Hospital Infection Control Committee. Should the Committee find plausible and acceptable explanations for the six infections — unusually susceptible hosts, unusual surgical risk factors such as repeat operations, etc. — well and good. If not, further inquiry is carried out to determine why the infection rate is above the SFHCIC standard, and measures to correct this are instituted. Surveillance is, of course, continued.

Added benefits to SFHCIC hospitals include regular educational programs for medical and nursing staff and regular on-site prevention walk rounds ("prevalence rounds") to correct potentially bad situations before cross-infections occur. Monetary savings can also be demonstrated. Elimination of unnecessary microbiological environmental tests, avoidance of unnecessary use of disinfectants or selection of less costly disinfectants which are as effective as more expensive ones have all been done with safety.

Costs and patterns of overutilization of single patient isolation were examined at five SFHCIC hospitals between 1971 and 1974; 4% to 62% of single isolated patients were found to have been

overisolated, that is, unnecessarily confined to a more expensive single room only because of a physician's concern for spread of infection when a semiprivate room was in fact medically acceptable. The annual excess of single room isolation was from 100 to 633 days and unnecessary annual hospital charges ranged up to \$46,000. Since single rooms are at times difficult to obtain — especially in the crush of the winter season when tourist influxes greatly increase the population here requiring health care — reduction in unnecessary overisolation results in greater availability of hospital beds at scarce times. Patient care improves because nursing contact is greater when strict isolation ceases. It was found that determination of isolation type and duration can safely be delegated to infection control personnel, with a consequent reduction of patient care costs and improved utilization of hospital facilities. There was no increase in cross-infection when infection control personnel, rather than individual physicians, carry out these less restrictive isolation practices.

While methodology for infection control continues to develop, the fact of multiple hospital cooperation in this patient care realm is highly praiseworthy. In a larger sense, SFHCIC provides an important measurement of the quality of care in South Florida hospitals. Another multihospital cooperative program for infection control is now functioning in the Tampa Bay area under the leadership of Dr. Charles Craig, and a SFHCIC—Tampa interchange of data is contemplated. If similar programs are developed elsewhere in the state — in Jacksonville, Orlando and Tallahassee especially — and if all groups will use common criteria and techniques for obtaining surveillance data which can then be shared among them, an objective and reliable statewide standard of this aspect of health care will become apparent.

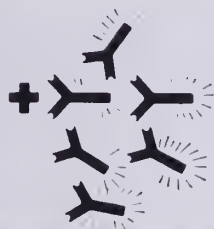
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- Dr. Ehrenkranz, Cedars of Lebanon Hospital, Miami 33152.

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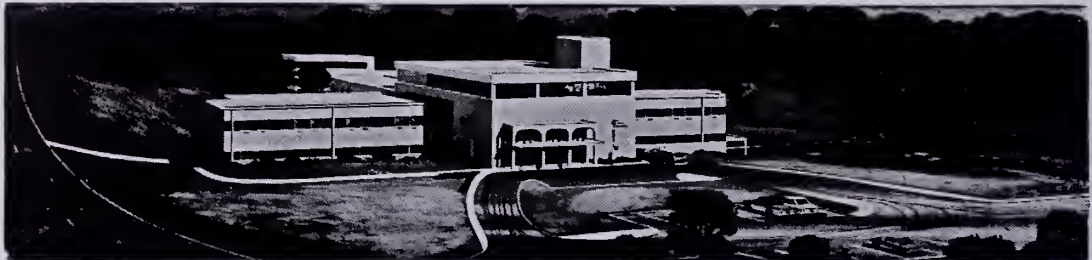
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MARCH 31 — APRIL 4, 1978

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EARLY REGISTRATION SUGGESTED

Our Decision

A symposium entitled "To Live, To Die — Who Decides?" presented at the Seventieth Annual Scientific Assembly of the Southern Medical Association last November in New Orleans, had for its panel, an oncologist, a pathologist, a professor of ethics and theology, an attorney, a psychiatrist and Dr. Alton Ochsner. They produced some impressive arguments that the turmoil surrounding deaths and the dying process is not new but merely re-emphasized today because such extraordinary medical things can now be done to us.

The physician oncologist described a Bill of Rights for the dying patient, beginning with the right of pain, obligating a limitation to suffering, yet helping preserve the patient's second right, that of identity. The third is that of cost estimate or what is it worth to stay alive. The fourth, the right of knowledge or the right to know the facts, is followed by the right of consent or dissent. Then is the right of religion plus the right of culture, the former illustrated by the devout Jehovah's Witness, the latter by the wish to expect consideration of his cultural differences. Next comes the right of hope followed by the right of care, or the confidence that his doctor or a sympathetic surrogate will always be available for relief of anxiety or pain. And finally, the right of death concluding the list, all being a part of the unwritten contract between a physician and his patient.

The psychiatric panelist admonishes us as physicians to understand the fine but critical line between a positive action that leads to death and the withholding or withdrawing of forms of therapy that prolong life without benefiting the patient. Further recommendations were that we who are involved in keeping a patient alive must put his needs and values foremost, and prevent any consideration of

the dying patient's welfare being unjustly sacrificed for the qualms and guilts of the relatives or society.

Pointing out that our profession, along with the clergy, primarily deals with death, another speaker stressed that we must have the courage to stand up and express our convictions to work within the framework of the law, striving for change, trusting that society will consider shortening the process of dying where it is destructive, denigrating and dehumanizing.

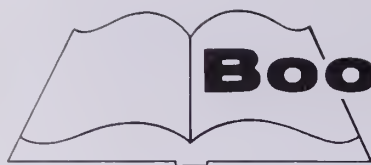
Another panelist questions the worth of the proportion of our nation's health facilities now being utilized in keeping pain ridden, terminally ill patients alive while other people do not receive the bare rudiments of adequate health care. How much of our nation's wealth and medical professionals should be segregated to such care and who will be the ultimate arbiter were questions raised? Such decisions, albeit painful, should fall upon the shoulders of trained physicians.

In a recent book, entitled "The Healer's Art," Dr. Eric J. Cassell draws a distinction between curing a disease, a technical procedure and healing an illness, a humane procedure. Because of modern medicine's striking success with the first, he says that we have ignored the second, for it is easier to deal with the germ than the patient. Understandably this is likely to send terminally ill patients looking elsewhere to fill the needs they deeply feel.

In our continuing medical education courses, one of the many lessons we should learn and teach is rather apparent.

Clyde M. Collins, M.D.
Jacksonville

Dr. Collins is in the private practice of Surgery and an Associate Editor of the Journal.



Book Reviews

Book Review Editor

F. Norman Vickers, M.D.

Currents in Alcoholism, Biological, Biochemical and Clinical Studies, Vol. 2, edited by Frank A. Seixas, M.D. 548 Pages. Illustrated. Price \$19.50. New York, Grune & Stratton, 1977.

Within the overwhelming total of 1,043 pages comprising these two volumes, only a scant 33 pages expound on evaluation of alcoholism treatment methods, mildly shocking evidence of our low level of development in this important area. These are a smorgasbord of presentations made at a conference in Washington, D.C., on May of 1976. The mystery of the early publication date (about a year after the meeting was held) is solved by a reference to what appears to be a new lithographic procedure, "Grune and Stratton Rapid Manuscript Reproduction." Should one be grateful for this unconventional rushing into print?

Many of the basic science papers included are of interest only to a limited audience; some of the "preliminary communications" could have been abstracted or omitted with no great danger of regression in the field. One example is the much heralded (in the lay press) biochemical marker of alcohol consumption, the relationship between plasma Alpha-amino-Butyric acid and Leucine. Perhaps this is the greatest boon to objective biochemical diagnosis of the condition in our patients — but one can effortlessly wait for more solid, confirming evidence.

There are, in addition, in Volume I the expected laboratory studies of inebriated rats, with the natural consequences intoxication produces in a compliant rodent population; and brief nosologic articles, using the two-track diagnostic criteria sponsored by the National Council on Alcoholism. Serene descriptions of traditional treatment settings round up the tome. Volume II concentrates on epidemiology, psychiatry and the above noted three short evaluation papers.

Dr. Frank Seixas, the highly respected medical director of the National Council, and a tireless crusader for better clinical management of alcoholics, edited these two books as a labor of love. One might hope that by the time he edits the

proceedings of the next annual conference, he would have loved not so well, but more wisely and succinctly.

This twin publication is much too expensive for the average clinician. Unfortunately, it is not profound enough or useful enough for a reference library.

Jose J. Llinas, M.D.
Gainesville

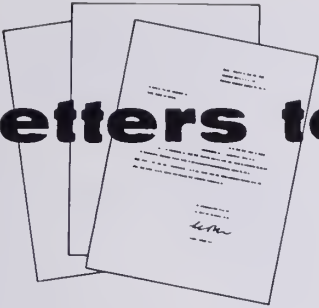
Dr. Llinas is Executive Director, North Central Florida Community Mental Health Center and Professor of Psychiatry, University of Florida College of Medicine, Gainesville.

Apostles and Prophets, Medicine for Society's Ills, by Frederick Ebersson, Ph.D., M.D. 106 Pages, Illustrated. Price \$6.00. Exposition Press, 1977.

In this day when self-centeredness and mediocrity are common and even exalted, it is easy to lose sight of the fact that great advances in thought and social practice are frequently the result of the dedicated efforts of one or a few individuals. In this short volume, Dr. Frederick Ebersson skillfully sketches the contributions and salient biographical information of four giants in the field of public health: Francois Joseph Callot, Johann Peter Frank, Max Von Pettenkofer and John Alfred Ryle. These men whose lives collectively span almost three hundred years, dedicated their lives to the study and remedy of those diseases spawned by inadequate food and water supply, poor sewage disposal, crowded urban living and above all poverty. The layman and physician alike will find Dr. Ebersson's account exciting not only as a sketch of the development of modern public health concepts, but also as a warm and intimate description of the personalities of these great men.

William M. Straight, M.D.
Miami

Dr. Straight is in the private practice of Internal Medicine and he is also Historical Editor for the Journal.



Letters to the Editor

To the Editor: I congratulate you and Dr. Enrique Huertas on the August 1977 issue of the Journal of the Florida Medical Association.

This is an excellent historical issue and pays rightful tribute to the many hard working and honorable Cuban physicians who have been forced from their homeland and overcome many adversities in adjusting to practice in the United States and in Florida.

One has only to imagine the difficulties that anyone of us would encounter if we were to be suddenly transported to a Spanish speaking country and forced to overcome the language barrier in addition to the many cultural and professional differences between our people. Furthermore, most of these physicians were forced to sacrifice most of their assets and often some of their loved ones in order to once again achieve the right to practice in freedom.

Again, congratulations on honoring these physicians and their heritage.

Vernon B. Astler, M.D.
Boynton Beach

George S. Palmer, M.D., Executive Director
State Board of Medical Examiners
305 Blount Street
Tallahassee, Florida 32304

Dear George:

In my letter of August 4th I expressed concern regarding the ability of physicians suspected of practicing in an unacceptable manner to continue practice while the already overloaded court system is waiting to hear the case.

Apparently, however, I have been told that the Board of Medical Examiners now has the power,

granted only recently, to suspend licenses of physicians pending a formal court hearing. This would be invoked only if the doctor has refused to accept the decision of the Peer Review Committee at a local level.

My primary interest is not in the "Sick Doctor Act" involving alcoholism, drug abuse and/or psychiatric or physical illness, but primarily those practitioners who violate acceptable standards of practice whether they be medical or surgical.

It is imperative that statutory and administrative regulations must provide for speedy hearings and early final decisions of any appellate procedure **so that the malpractitioners not be allowed to continue practicing almost indefinitely while they obtain continuances and undertake other delaying tactics.**

I await your reply with interest.

David J. Lehman, M.D.
State Representative
District 97
Hollywood

David J. Lehman, M.D.
Representative District 97
2740 Hollywood Boulevard
Hollywood, Florida 33020

Dear Dave:

This is in response to your letters of August 4, 1977.

Our Board definitely would like legislation which would allow licensure suspension to remain in force while appeals grind through the courts.

Contrary to what you have been told, our Board does not now have the emergency power to suspend licenses of physicians who are charged

with incompetence or unprofessional conduct by any group of their peers. We would like to have this emergency power in dealing with the medically and surgically incompetent physicians just as we have this power in dealing with the Sick Physician. We would like to be able to issue an emergency suspension and then set up a hearing within sixty days as is the case with a Sick Physician. We should be able to do this with an incompetent physician and let the burden of proof be upon him or her to show cause at the hearing why the suspension should not remain in effect.

Also, in response to your letter on present statutes on the books regarding "Fifth Pathway," entrance into medical licensure requires the following on any applicant who qualifies for licensure under "Fifth Pathway."

- 1) Has completed undergraduate work in an accredited United States college or university.
- 2) Has studied at a medical school which is recognized by the World Health Organization.
- 3) Has completed all of the formal requirements of the foreign medical school except the internship or social service requirement.
- 4) Has completed an academic year of supervised clinical training (Fifth Pathway Program) in a hospital affiliated with a medical school approved by the Council on Medical Education of the AMA.
- 5) Has passed parts I and II of the National Board of Medical Examiners or the ECFMG equivalent.
- 6) Has completed one year of AMA approved training.
- 7) Has been a bona fide resident of the State of Florida for one year.

SB 877 has no effect on "Fifth Pathway" legislation. We now accept as "Fifth Pathway Programs" a year of supervised clinical clerkship training in any hospital which is affiliated with a recognized medical school. This includes many hospitals in our state which are affiliated with one of the three medical schools.

Thank you for your interest and support in these important matters which will make our disciplinary powers more efficient, active, and effective.

George S. Palmer, M.D.
Executive Director
State Board of Medical Examiners
Tallahassee

Editor's Note: Dr. McCormack's letter to Mr. Page was written last February. Twice The Journal has asked Secretary Page for a comment, but no reply has been received; thus, the delay in publishing Dr. McCormack's letter.

Mr. William J. Page Jr., Secretary
Department of Health & Rehabilitative Services
1323 Winewood Boulevard
Tallahassee, Florida 32301

Dear Mr. Page:

In response to your letter of sometime ago, in regards to the Medicaid program running out of money; it seems to me I have heard this song before about five years ago when the already inadequate medical fees were cut drastically. To the best of my knowledge no one else had their payments or salaries reduced.

Let us all make equal sacrifices to aid the program this time around. It seems only fair that **all** payments be reduced by the same percentage. All salaries paid by Medicaid reduced the same as you reduce my payments. Naturally, this should apply to rent paid on buildings, utility bills, nursing home payments, car maintainance, gasoline bills, stamps, druggist bills, printing bills, etc.; in fact any bill paid by Medicaid for goods or services.

Our politicians set up these programs and then do not fund them adequately. I am tired of my profession receiving the blame and my pocketbook, only, suffering the damage.

To the best of my knowledge, I am the only physician in my rural county accepting Medicaid for office calls. If costs are reduced as I have outlined above, I will go along with reduced reimbursement. If doctors alone are singled out, I drop out. A notice has been placed in my waiting room to this effect.

I do not think this is an extreme stand. It will be interesting to see how many of your employees stay, how many stamps you receive, how long you receive heat and phone service when you reduce payments over 50% as you did to me last time.

Lloyd L. McCormack, M.D.
DeFuniak Springs

**Pride is something we have.
Vanity is something others have.**



Francis T. Holland, M.D., of Tallahassee . . . was honored by his colleagues for his many accomplishments during the annual Tallahassee Medical Seminar Luncheon on September 15.

Dr. Holland, who completed a one-year term as Vice President of the American Medical Association last summer, was presented with a scroll and gift in appreciation for his many contributions.

In 1975 the Florida Legislature adopted a resolution commending Dr. Holland for "his untiring efforts and his dedication to making our state's highways safer for all motorists, for serving 22 years as chairman of the volunteer medical advisory board to the division of driver licenses of the department of highway safety and motor vehicles, for evaluating more than 27,000 medical reports to determine if those licensed drivers and applicants were capable of safely operating motor vehicles on our roadways . . ."

Prior to his year as Vice President of AMA, Dr. Holland served for more than 20 years as a Florida delegate to the AMA.

His many honors include the Certificate of Appreciation of the AMA (1970) and the Certificate of Merit of the Florida Medical Association.

Edward R. Annis, M.D., of Miami . . . represented the Florida Medical Association at a federal hearing on national health insurance in Jacksonville on October 6.

The lead-off speaker, Dr. Annis said catastrophic coverage should be the keystone of any NHI program developed by the Carter Administration. He referred to Department of Health, Education and Welfare statistics that only about half of all Americans have such protection.

A program covering all health expenses would

result in an astronomical costs, he said, and the public needs to know how much any national program is going to cost.

Many Americans eat, drink and smoke too much, he continued, and simple changes in lifestyle could reduce health care costs significantly.

"National Health Insurance is one of the most controversial and complex issues facing the federal government in this century," Dr. Annis said. "However, the solutions to these problems must be realistic and rest not only with the government, but with the American people, and their choice of life style.

"Doctors and hospitals can take care of all health problems, but the maintenance of good health habits is 90 per cent the responsibility of the individual."

Pointing out that medical care in the United States exceeds that elsewhere in the world both qualitatively and quantitatively, he added:

"We must have a realistic assessment of our resources and realize that there is no single way to administer health services to all but rather should be channeled through individual communities. We must learn from our mistakes with Medicare and Medicaid, and come up with realistic sharing of costs among all people for health care."

Dr. Annis participated as a participant in a panel which also included representatives of the Florida Hospital Association, Blue Cross and Blue Shield, pharmacy and retired teachers.

The Jacksonville hearing was one of 13 conducted last month at the request of the Secretary of HEW in the HEW Region IV area. The other hearings included sessions in Tampa on October 4 and in Miami on October 7.

An affiliation agreement . . . has been negotiated between the University of Miami School of Medicine and the National Parkinson Foundation.

The contract calls for a one-year study designed to foster a long term relationship devoted to research into prevention and treatment of Parkinsonism.

Under the agreement, Lee Alan Bricker, M.D., Associate Professor of Medicine at Miami, is named directing medical consultant to the Foundation. A Medical-Scientific Advisory Board will be chaired by Dr. Thomas Chase of the National Institutes of Health and will include University of Miami faculty.

MEETINGS

Approved by FMA Committee on Continuing Medical Education

DECEMBER

The Pill — New Findings and Side Effects, Dec. 1, Florida State University, Tallahassee. For information: Philip C. Rond, M.D., University Health Center, Florida State University, Tallahassee 32306.

Laparoscopy: Diagnostic and Therapeutic Techniques, Dec. 1-3, Contemporary Resort Hotel, Lake Buena Vista. For information: H. Worth Boyce, Jr., M.D., 12901 North 30th St., Tampa 33612.

Basic Clinical Electrocardiography and Arrhythmia Management, Dec. 2-4, Royal Biscayne, Miami. For information: William E. James, Ph.D., One Inverness Drive, Englewood, Colorado 80110.

Fall Meeting of the Florida Pediatric Society, Dec. 2-4, Contemporary Inn at Walt Disney World. For information: James A. Hallock, M.D., 12901 N. 30th Street, Tampa 33605.

Pediatric Nephrology and Gastroenterology, Dec. 3, Gainesville.**

The Vitreous, Dec. 7-9, Miami.*

The Heart, Dec. 8, Florida State University, Tallahassee. For information: Philip C. Rond, M.D., University Health Center, Florida State University, Tallahassee 32306.

Pediatric Anesthesia, Dec. 8-11, Miami.*

Medical Surgical Seminar, Dec. 9-10, St. Francis Hospital, Miami Beach. For information: Lawrence R. Medoff, M.D., 250 West 63rd Street, Miami Beach 33141.

5th Annual Symposium on the Management of Sexual Problems, Dec. 9-11, Gainesville Hilton, Gainesville.**

5th Annual Symposium on the Treatment of Common Sexual Problems, Dec. 9-11, Don CeSar Beach Resort Hotel, St. Petersburg.**

31st Winter Scientific Meeting, AMA, Dec. 10-13, Fontainebleau Hotel, Miami Beach. For information: Alice Harvey, Program Coordinator, AMA, 535 N. Dearborn St., Chicago 60610.

Intraocular Lenses, Dec. 12-15, Miami.*

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Dec. 12-17, Miami.*

*For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152, Tel. (305) 547-6716.

**For Information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143.

+For Information: Contact Theron A. Ebel, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2074.

1978

JANUARY

Fifth Annual Symposium in Pediatric Nephrology: Current Concepts in Diagnosis and Management, Jan. 4-7, Miami.*

Management for the Physician and Dentist, Jan. 5, Americana Hotel, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

Fifteenth Annual Postgraduate Seminar in Anesthesiology, Jan. 5-8, Americana Hotel, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

Cardiac Arrhythmias, Jan. 6-8, Omni International Hotel, Miami. For information: Ralph Lassara, M.D., Veterans Administration Hospital, 1201 N.W. 16th Street, Miami 33125.

Post Convention Seminar in Anesthesiology, Jan. 8-13, Sam Lord's Castle, Barbados, B.W.I. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

Miami Winter Symposia, Jan. 9-12, Miami.*

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Jan. 9-14, Miami.*

Third Annual Seminary, "Problems in Pediatric Radiology", Jan. 13-17, Sonesta Beach Hotel and Tennis Club, Key Biscayne.*

Postconvention Seminar in Pediatric Radiology "Radiographic-Pathologic Correlation of Pediatric Diseases," Jan. 17-20, The Colony Beach and Tennis Resort, Sarasota.*

Art and Science in the Therapy of Difficult Problems in Surgery, Jan. 18-21, Miami.*

10th Annual Postgraduate Seminar in Pediatric & Adult Urology, Jan. 19-21, Carillon Hotel, Miami Beach. For information: Victor Politano, M.D., 3900 Northwest 79th Ave., Suite 469, Miami 33166.

Advances in Endocrinology '78, Jan. 20-21, Hyatt House, Kissimmee. For information: Samuel E. Crockett, M.D. or Barry E. Seiger, M.D., 1416 S. Orange Avenue, Orlando 32806.

Corneal and Plastic Ophthalmic Surgery and Diseases of the Eye, Jan. 22-27, Miami.*

3rd Annual Review and Recent Practical Advances in Pathology, Jan. 22-27, Miami.*

A Neurological Update: 1978, Jan. 23-27, Miami.*

3rd International Symposium on Stress, Jan. 26-27, Gainesville Hilton, Gainesville.**

Lung Cancer Update 1978 — Diagnosis, Staging and Treatment, Jan. 26-27, Medical Center Auditorium, Tampa. For information: David A. Solomon, M.D., 13000 N. 30th Street, Tampa 33612.

Cancer Chemotherapy, Jan. 27, Veterans Administration Center, Bay Pines. For information: John C. Gallagher, M.D., Veterans Administration Center, Bay Pines 33504.

Coronary Disease, Exercise, Testing and Cardiac Rehabilitation, Jan. 27-29, Orlando Hyatt House, Orlando. For information: William E. James, Ph.D., One Inverness Dr., Englewood, Colorado 80110.

Thirteenth Annual Scientific Assembly of the American Society of Contemporary Medicine and Surgery, Jan. 30-Feb. 3, Americana Hotel, Miami Beach. For information: John G. Bellows, M.D., 6 North Michigan Avenue, Chicago 60602.

FEBRUARY

Twelfth Annual Symposium on Cosmetic Surgery, Feb. 2-4, Cedars of Lebanon Hospital, Miami. For information: Thelma MacGregor, Seminar Sec., Cosmetic Surgery Symposium, Cedars of Lebanon Hospital, 1400 NW 12th Avenue, Miami 33136.

Florida Cleft Palate Association Annual Meeting, Feb. 3-4, Konover Hotel, Miami Beach. For information: William Silver, M.D., 6950 North Kendall Drive, Miami 33156.

23rd Central Florida Medical Meeting, Feb. 3-5, Contemporary Resort Hotel, Orlando. For information: Edward Ackerman, M.D., 800 West Morse Blvd., Winter Park 32789.

Management of Cardiac Disease — 1978, Feb. 3-5, Omni International Center, Miami. For information: Robert J. Myerburg, M.D., and Agustin Castellanos, Jr., M.D., Division of Cardiology, University of Miami, P.O. Box 520875, Miami 33152.

Fourth Annual Fall Conference in Anesthesiology, Feb. 4-11, Miami.*

OB-GYN Caribbean Seminar, Feb. 4-11, Miami.*

Thirteenth Annual Postgraduate Course — Internal Medicine 1978, Feb. 5-10, Sheraton Four Ambassadors Hotel, Miami. For information: J. Bocles, M.D., University of Miami School of Medicine, Department of Internal Medicine, P.O. Box 520875, Miami 33152..

Clinical Nephrology and Hypertension, Feb. 6-8, Doral Beach Hotel, Miami. For information: Office of CME Mount Sinai Medical Center, 4300 Alton Road, Miami Beach 33140.

Florida Midwinter Seminar in Ophthalmology, Feb. 6-8, Miami.*

13th Annual "Internal Medicine 1978," Feb. 6-11, Miami.*

Florida Midwinter Seminar in Otolaryngology, Feb. 9-11, Miami.*

Internal Medicine Update '78, Feb. 13-18, Dutch Inn, Lake Buena Vista. For information: Barry E. Sieger, M.D. or Samuel E. Crockett, M.D. or Roy Behnke, M.D., 1416 S. Orange Avenue, Orlando 32806.

Basic Clinical Electrocardiography and Arrhythmia Management, Feb. 17-19, Bahia Mar, Fort Lauderdale. For information: William E. James, Ph.D., One Inverness Drive, Englewood, Colorado 80110.

Pediatric Dermatology Seminar, Feb. 23-26, Konover Hotel, Miami Beach. Program to be followed by a one week post seminar flight and cruise to the Caribbean and South America. For information: Guinter Kahn, M.D., 16800 N.W. 2 Ave., Suite 401, N. Miami Beach 33169.

Basic Neurology for Psychiatrists, Family Practitioners and General Practitioners, Feb. 26-Mar. 3, Miami.*

MARCH

Hepatobiliary Disease in Clinical Practice, Mar. 2-4, Miami.*

5th Annual Selected Topics in Urology, Mar. 2-4, Gainesville Hilton, Gainesville.**

First International Congress on Colonoscopy and Diseases of the Large Bowel, Mar. 2-4, Fontainebleau Hotel, Miami Beach. For information: John P. Christie, M.D., 7400 N. Kendall Drive, Suite 311, S. Miami 33156.

Perinatology II High Risk Pregnancy Conditions and Their Management, Mar. 2-4, Hyatt House, Orlando. For information: Amelia C. Cruz, M.D., University of Florida College of Medicine, Department of Obstetrics and Gynecology, Box J-294, JHMC, Gainesville 32610.

Management of Diabetes Mellitus, Mar. 3, Veterans Administration Center, Bay Pines. For information: John C. Gallagher, M.D., Veterans Administration Center, Bay Pines 33504.

3rd Annual Conference in Skin Disorders for Nurses, Mar. 3-5, Miami.*

Postgraduate Seminar in Dermatology, Mar. 3-5, Miami.*

Eighth Annual Radiological Special Procedures Seminar, Mar. 4-7, Konover Hotel, Miami Beach. For information: Mrs. Lucy Kelley, 6752 S.W. 34th Court, Miramar 33023.

16th Annual Clinical Radiology Seminar "Controversies in Radiology," Mar. 7-11, Konover Hotel, Miami Beach. For information: Mrs. Lucy Kelley, 6752 S.W. 34th Court, Miramar 33023.

2nd Annual Seminar "Practical Aspects of Computed Tomography", Mar. 12-15, Konover Hotel, Miami Beach.*

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Mar. 13-18, Miami.*

Practical Aspects of Ultrasonography, Mar. 15-18, Konover Hotel, Miami Beach.*

Infectious Disease and Immunology, Mar. 17-18, Dutch Inn, Lake Buena Vista. For information: Barry E. Sieger, M.D. or Samuel E. Crockett, M.D., 1416 South Orange Avenue, Orlando 32806.

Current Clinical Concepts in Otolaryngology, 1978, Mar. 22-24, Miami.*

Tenth Teaching Conference in Clinical Cardiology, Mar. 22-25, Americana Hotel, Miami Beach. For information: Michael S. Gordon, M.D., Ph.D., University of Miami School of Medicine, Division of Cardiology, P.O. Box 520875, Biscayne Annex, Miami 33152.

9th Annual Topics in Internal Medicine, Mar. 23-25, Gainesville Hilton, Gainesville.**

Seminar for Chronic Pain, Mar. 31 - Apr. 2, Americana Hotel, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

APRIL

Malignant Hyperthermia, Apr. 6-9, Miami.*

Tutorial Courses of instruction in Coronary Care for the Practicing Physician, Apr. 10-15, Miami.*

Obstetric Anesthesia — Fourth Annual Seminar in Memory of Virginia Apgar, M.D., Apr. 14-16, Americana Hotel, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

Pediatric Anesthesia — Fourth Annual Seminar in Memory of Virginia Apgar, M.D., Apr. 14-16, Americana Hotel, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

Sixth Annual Intensive Care Symposium, Apr. 15-17, Miami.*

Emergencies in Internal Medicine, Apr. 17-20, Miami.*

Advanced Electrocardiography and Arrhythmia Management for the Family Practitioner, Apr. 20-22, Gainesville Hilton, Gainesville.**

MAY

Second Annual Symposium on Underwater Medicine, May 4-8, Miami.*

Seizure Disorders, May 5, VA Center, Bay Pines. For information: John C. Gallagher, M.D., Chairman, Education Committee, VA Center, Bay Pines 33504.

Post-Convention Seminar and Diving Program, May 8-11, Miami.*

Pars Plana Vitreous Surgery - The Miami Technique, May 11-13, Miami.*

Family Medicine Update — 1978, May 18-21, Miami.*

7th Family Practice Review, May 22-26, Gainesville Hilton, Gainesville.**

JUNE

Review Course for Certification in Internal Medicine, June, Miami.*

Bascom Palmer Eye Institute Alumni Meeting and Seminar, June 9-11, Miami.*

Coronary Disease, Exercise Testing and Cardiac Rehabilitation, June 23-25, Orlando Hyatt House, Orlando. For information: William E. James, Ph.D., One Inverness Drive, Englewood, Colorado 80110.

Fifth Annual Postgraduate Seminar in Respiratory Care, June 23-25, Americana Hotel, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

Seminar for Intensive and Critical Care Personnel, June 23-25, Americana Hotel, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140

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Two research projects aimed at finding a better feeding formula for low birth weight infants are being conducted by pediatricians at the University of South Florida in Tampa.

The projects are under the direction of Lewis A. Barness, M.D., Professor and Chairman of the Department of Pediatrics at the USF College of Medicine. The studies are supported by \$30,000 in grants from Wyeth Laboratories.

One project is being carried out at Tampa General Hospital by John Curran, M.D., Associate Professor of Pediatrics. It is a study of hyponatremia in premature infants, and Dr. Curran is observing infants on a routine formula to see if they develop this blood salt deficiency.

At All Children's Hospital in St. Petersburg, Robert Sosa, M.D., Assistant Professor of Pediatrics is conducting a study on "Biologic Value of Milk Protein." He is attempting to determine the effect of dietary fat in routine formula feedings on amino acids in the blood of premature infants.

Deaths

Angel, Norman S., Fort Myers; born 1910; Chicago Medical School, 1938; member AMA; died June 13, 1977.

Bates, Thomas H., Lake City; born 1891; Tulane University, 1913; member AMA; died June 20, 1977.

Black, Robert C., Orlando; born 1880; Birmingham College of Medicine, 1905; member AMA; died August 2, 1977.

Cippes, Isaac B., Miami; born 1903; Jefferson Medical School, 1927; member AMA; died July 9, 1977.

Davis, Jack E., Fort Myers; born 1919; University of Illinois, 1940; member AMA; died June 11, 1977.

Faura-G, Jose, Orlando; born 1930; Havana Medical School, 1960; member AMA; died September 10, 1977.

Halperin, Bernard, Miami Lakes; born 1923; Chicago Medical School, 1950; member AMA; died June 29, 1977.

Kiester, Kenneth D. Jr., Fort Lauderdale; born 1934; Oklahoma University, 1959; member AMA; died July 29, 1977.

Massey, Bennie J., Palatka; born 1920; Medical College of State of South Carolina, 1948; member AMA; died May 10, 1977.

Mendelson, Joel, Ormond Beach; born 1918; Emory University, 1950; member AMA; died June 26, 1977.

Mitchell, John H., Jacksonville; born 1901; Vanderbilt University, 1927; member AMA; died September 10, 1977.

Perry, Joseph Q., Pensacola; born 1920; University of Louisville, 1943; member AMA; died September 10, 1977.

Randolph, John W., Atlantis; born 1925; Miami Medical School, 1961; member AMA; died April 9, 1977.

Stark, Stanley, West Palm Beach; born 1920; Middlesex University, 1945; member AMA; died April 9, 1977.

Vetter, Karl W., Coral Gables; born 1908; Indiana University, 1931; member AMA; died August 2, 1977.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

ANTIMINTH® (pyrantel pamoate)

ORAL SUSPENSION

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 $\mu\text{g/ml}$) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

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ORAL SUSPENSION



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Choledyl® (oxtriphylline) Tablets and Elixir CAUTION: Federal law prohibits dispensing without prescription. Each partially enteric coated tablet contains 200 mg or 100 mg oxtriphylline. Each teaspoonful of the elixir contains 100 mg oxtriphylline; alcohol 20%. **Indications:** Choledyl (oxtriphylline) is indicated for relief of acute bronchial asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema. **Warning:** Use in pregnancy — animal studies revealed no evidence of teratogenic potential. Safety in human pregnancy has not been established; use during lactation or in patients who are or who may become pregnant requires that the potential benefits of the drug be weighed against its possible hazards to the mother and child. **Precautions:** Concurrent use of other xanthine-containing preparations may lead to adverse reactions, particularly CNS stimulation in children. **Adverse Reactions:** Gastric distress and, occasionally, palpitation and CNS stimulation have been reported. **Dosage:** Average adult dosage: Tablets — 200 mg, 4 times a day; Elixir — two teaspoonfuls, 4 times a day. **Supplied:** 200 mg yellow, partially enteric coated tablets in bottles of 100 (N 0047-0211-51) and 1000 (N 0047-0211-60); Unit Dose — 200 mg tablets (N 0047-0211-11); 100 mg red, partially enteric coated tablets in bottles of 100 (N 0047-0210-51). Elixir — bottles of 16 fl oz (1 pint) 474 ml (N 0047-0215-16). **Toxicity:** Oxtriphylline, aminophylline and caffeine appear to be more toxic to newborn than to adult rats. No teratogenic effects have been seen. Full information is available on request.

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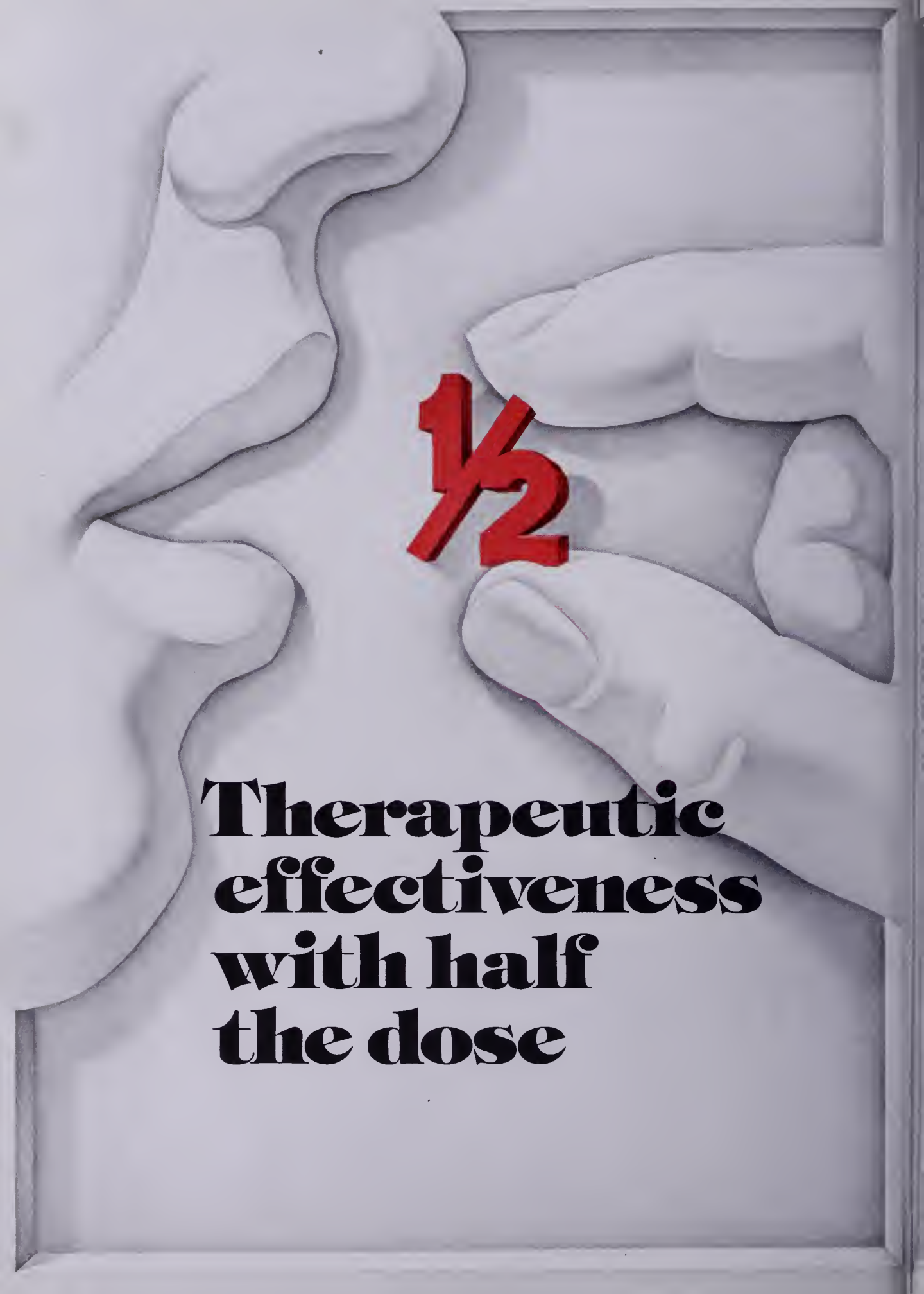
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See Clinical Considerations section on following page.

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Clinical Considerations: INDICATIONS FULVICIN P/G Tablets are indicated for the treatment of ringworm infections of the skin, hair, and nails, namely: tinea corporis, tinea pedis, tinea cruris, tinea barbae, tinea capitis, tinea unguium (onychomycosis) when caused by one or more of the following genera of fungi: *Trichophyton rubrum*, *Trichophyton tonsurans*, *Trichophyton mentagrophytes*, *Trichophyton interdigitalis*, *Trichophyton verrucosum*, *Trichophyton megnini*, *Trichophyton gallinae*, *Trichophyton crateriform*, *Trichophyton sulphureum*, *Trichophyton schoenleinii*, *Microsporum audouinii*, *Microsporum canis*, *Microsporum gypsum*, and *Epidermophyton floccosum*.

Note: Prior to therapy, the type of fungi responsible for the infection should be identified. The use of this drug is not justified in minor or trivial infections which will respond to topical agents alone.

Griseofulvin is not effective in the following: Bacterial infections, Candidiasis (Moniliasis), Histoplasmosis, Actinomycosis, Sporotrichosis, Chromoblastomycosis, Coccidioidomycosis, North American Blastomycosis, Cryptococcosis (Torulosis), Tinea versicolor, and Nocardiosis.

CONTRAINDICATIONS This drug is contraindicated in patients with porphyria, hepatocellular failure, and in individuals with a history of hypersensitivity to griseofulvin.

WARNINGS Prophylactic Usage: Safety and efficacy of griseofulvin for prophylaxis of fungal infections have not been established.

Animal Toxicology Chronic feeding of griseofulvin, at levels ranging from 0.5-2.5% of the diet, resulted in the development of liver tumors in several strains of mice, particularly in males. Smaller particle sizes result in an enhanced effect. Lower oral dosage levels have not been tested. Subcutaneous administration of relatively small doses of griseofulvin once a week during the first three weeks of life has also been reported to induce hepatomata in mice. Although studies in other animal species have not yielded evidence of tumorigenicity, these studies were not of adequate design to form a basis for conclusions in this regard.

In subacute toxicity studies, orally administered griseofulvin produced hepatocellular necrosis in mice, but this has not been seen in other species. Disturbances in porphyrin metabolism have been reported in griseofulvin-treated laboratory animals. Griseofulvin has been reported to have a colchicine-like effect on mitosis and cocarcinogenicity with methylcholanthrene in cutaneous tumor induction in laboratory animals.

Usage in Pregnancy The safety of this drug during pregnancy has not been established.

Animal Reproduction Studies: It has been reported in the literature that griseofulvin was found to be embryotoxic and teratogenic on oral administration to pregnant rats. Pups with abnormalities have been reported in the litters of a few bitches treated with griseofulvin. Additional animal reproduction studies are in progress.

Suppression of spermatogenesis has been reported to occur in rats, but investigation in man failed to confirm this.

PRECAUTIONS Patients on prolonged therapy with any potent medication should be under close observation. Periodic monitoring of organ system function, including renal, hepatic, and hematopoietic, should be done.

Since griseofulvin is derived from species of penicillin, the possibility of cross sensitivity with penicillin exists; however, known penicillin-sensitive patients have been treated without difficulty.

Since a photosensitivity reaction is occasionally associated with griseofulvin therapy, patients should be warned to avoid exposure to intense natural or artificial sunlight. Should a photosensitivity reaction occur, lupus erythematosus may be aggravated.

Griseofulvin decreases the activity of warfarin-type anticoagulants so that patients receiving these drugs concomitantly may require dosage adjustment of the anticoagulant during and after griseofulvin therapy.

Barbiturates usually depress griseofulvin activity, and concomitant administration may require a dosage adjustment of the antifungal agent.

ADVERSE REACTIONS When adverse reactions occur, they are most commonly of the hypersensitivity type, such as skin rashes, urticaria, and rarely, angioneurotic edema, and may necessitate withdrawal of therapy and appropriate countermeasures. Paresthesias of the hands and feet have been reported rarely after extended therapy. Other side effects reported occasionally are oral thrush, nausea, vomiting, epigastric distress, diarrhea, headache, fatigue, dizziness, insomnia, mental confusion, and impairment of performance of routine activities.

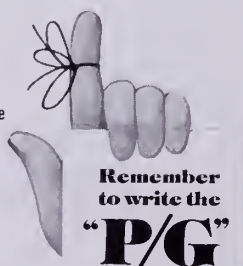
Proteinuria and leukopenia have been reported rarely. Administration of the drug should be discontinued if granulocytopenia occurs.

When rare, serious reactions occur with griseofulvin, they are usually associated with high dosages, long periods of therapy, or both.

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JANUARY, 1977

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INTERNIST-ENDOCRINOLOGIST, 30, ABIM certified, university trained. Seeks partnership or group practice in Southeast Florida beginning 7/78. Write C-830, P.O. Box 2411, Jacksonville, Florida 32203.

PEDIATRICIAN: 37 years old; Florida license, board eligible; neonatology subspecialty. Seeks partnership, group or hospital based practice. Desires relocation. Available January 1978. Contact: E. P. Nelson, M.D., 903 Hensley Heights, Man, West Virginia 25635.

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THORACIC CARDIOVASCULAR GENERAL SURGEON, now Clinical Professor of Surgery, wishes to transfer practice to Florida. Association or group desired. Hospital full time also considered. Write C-835, P.O. Box 2411, Jacksonville, Florida 32203.

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The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. **CNS reactions:** Headache,

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Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

***Pneumocystis carinii* pneumonitis:** Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

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Valium[®] (diazepam)[Ⓢ]

2-mg, 5-mg, 10-mg scored tablets
a prudent choice in psychic
tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

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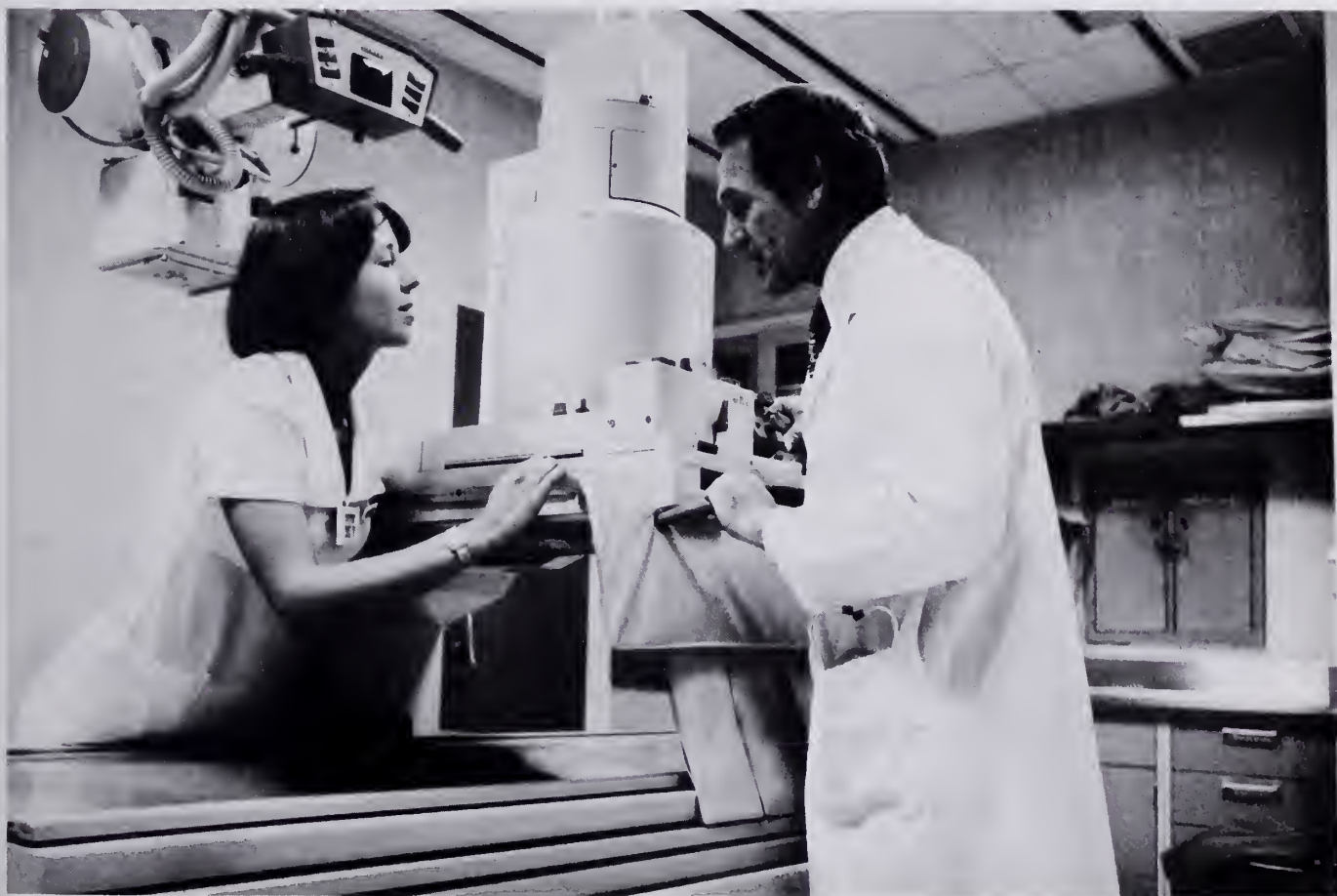
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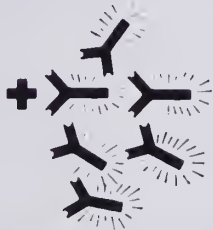
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Tuesday, January 31: CARDIOVASCULAR DISEASES (continued). Speakers: Leon Resnekov, Philip Samet, Bernard L. Segal, David Sheps, Ruey Sung, Henry Wagner, Jr. **HYPERTENSION** Chairman: John Laragh. Speakers: Frank Finnerty, Jr., James Hunt, Norman Kaplan, David Lowenthal, Robert Maronde. **PULMONARY DISEASES** Speakers: Maurice Segal, James Tennenbaum. **COSMETIC SURGERY** Chairman: Pierre Guibor. Speakers: Howard Beale, Crowell Beard, Richard Coburn, Frank Gillen, Robert Simons, Dowling Stough.

Wednesday, February 1: INFLAMMATORY BOWEL DISEASE Chairman: Joseph Kirsner. Speakers: Richard Farmer, Henry Janowitz, Martin Kalser, Burton Korelitz, Rene Menguy, Albert Weinfeld. **COMMON GASTROINTESTINAL PROBLEMS** Chairman: Arvey I. Rogers. Speakers: Jamie Barkin, Frank DeLand, Vicente Dinoso, Jr., Michael Levitt, Armand Littman, Albert Mendeloff, Daniel Paloyan, Herbert Sarett.

Thursday, February 2: CANCER Chairman: Joseph Painter. Speakers: Edward Beattie, Jr., William Cahan, Philip Exelby, Alfred Fracchia, Laurence Gardner, Ariel Hollinshead, Alfred Ketcham, Joe Levi, Alan Livingstone, Ralph Marcove, James Ozenberger, George Prout, Jr., Gerald Rosen, Charles Vogel, Horace Whiteley, Jr., C. Gordon Zubrod.

Friday, February 3: GENITOURINARY DISEASES Chairman: George Prout, Jr. Speakers: William Fair, T. W. Hensle, Gerald Mandell, Staffan Nordqvist, M. J. Vernon Smith, Louis Weinstein.

Completing the program will be a series of tutorial courses and workshops conducted by experts on: Cryosurgery, Endocrine Emergencies, The Management of Pain, The Pathogenesis and Management of Severe Acid-Base Abnormalities, Neuropsychiatric Manifestations of Systemic Disease, Sexual Function and Dysfunction, Beta-Adrenergic Blocking Agents, Biofeedback in Office Practice.

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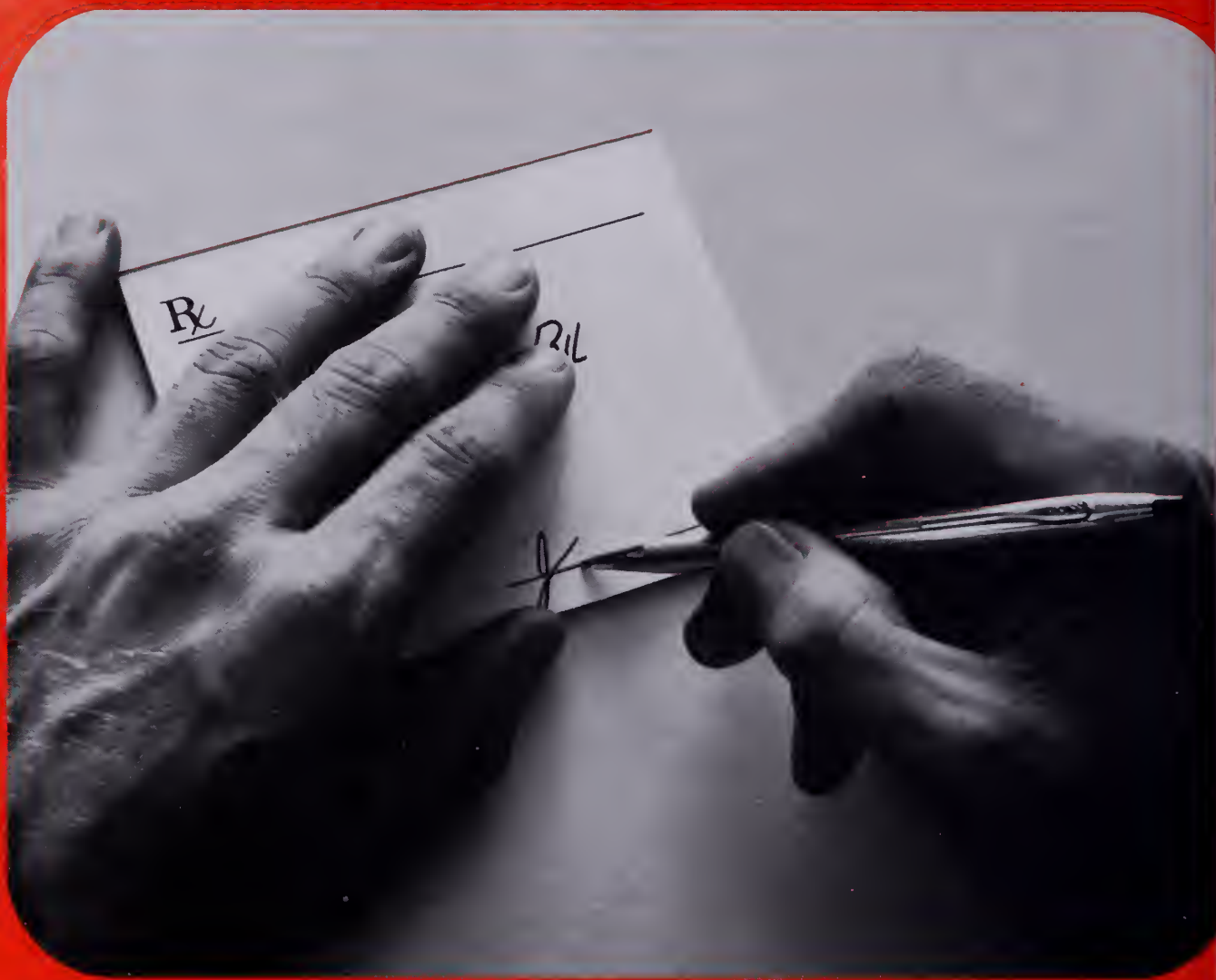
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Warnings: Use with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects may develop in patients with impaired renal function. Use with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. May add to or potentiate action of other antihypertensive drugs; potentiation occurs with ganglionic or peripheral adrenergic blocking drugs. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possibility of exacerbation or activation of systemic lupus erythematosus has been reported. Lithium generally should not be given with diuretics because they reduce its renal clearance and add a high risk of lithium toxicity. Read circulars for lithium preparations before use of such concomitant therapy.

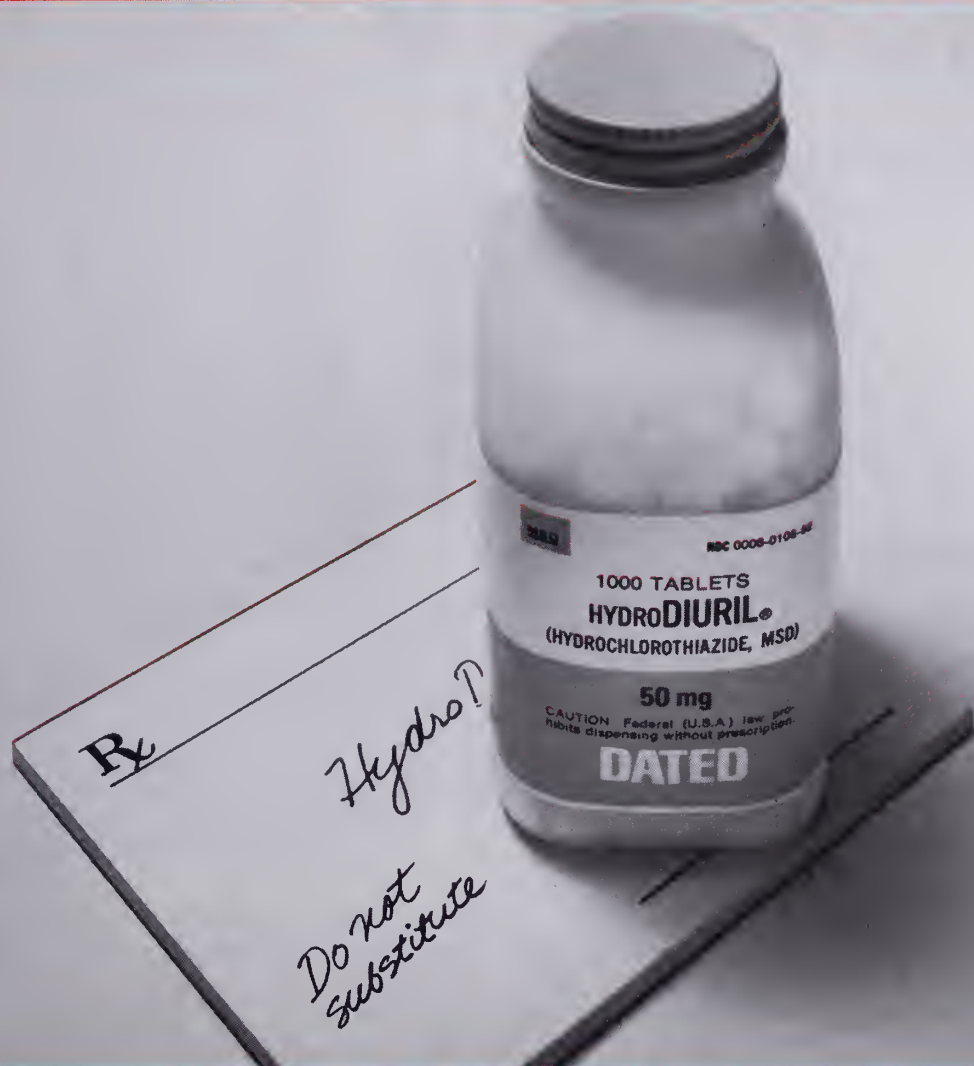
Use in Pregnancy: Thiazides cross placental barrier and appear in cord blood; in pregnancy, weigh anticipated benefit against possible hazards to fetus, including fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions that have occurred in adults.

Nursing Mothers: Thiazides appear in breast milk; if use of drug is deemed essential, patient should stop nursing.

Precautions: Perform periodic determination of serum electrolytes to detect possible electrolyte imbalance. Observe all patients for clinical signs of fluid or electrolyte imbalance, namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when patient is vomiting ex-

cessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting. Hypokalemia may develop, especially with brisk diuresis; in severe cirrhosis, with concomitant corticosteroid or ACTH therapy, or with inadequate oral electrolyte intake. Hypokalemia can sensitize or exaggerate response of heart to toxic effects of digitalis (e.g., increase ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content. Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice. Hyperuricemia may occur or frank gout may be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged; latent diabetes mellitus may become manifest. Thiazides may increase responsiveness to tubocurarine. Antihypertensive effects of the drug may be enhanced in post-sympathectomy patients. May decrease arterial responsiveness to norepinephrine; this diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use. If progressive renal im-

for experience—



or ours.

pairment becomes evident, consider withholding or discontinuing diuretic therapy. Thiazides may decrease serum PBI levels without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged therapy; thiazides should be discontinued before testing for parathyroid function.

Adverse Reactions: *Gastrointestinal System*—Anorexia; gastric irritation; nausea; vomiting; cramping; diarrhea; constipation; jaundice (intrahepatic cholestatic jaundice); pancreatitis; sialadenitis. *Central Nervous System*—Dizziness; vertigo; paresthesias; headache; xanthopsia.

Hematologic—Leukopenia; agranulocytosis; thrombocytopenia; aplastic anemia.

Cardiovascular—Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity—Purpura; photosensitivity; rash; urticaria; necrotizing angitis (vasculitis) (cutaneous vasculitis); fever; respiratory distress including pneumonitis; anaphylactic reactions.

Other—Hyperglycemia; glycosuria; hyperuricemia; muscle spasm; weakness; restlessness; transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

Note: When used with other antihypertensive drugs, careful observations for changes in blood pressure must be made, especially during initial therapy. Dosage of other antihypertensive agents must be

reduced by at least 50 percent as soon as this drug is added to the regimen. As blood pressure falls under the potentiating effect of this agent, further reduction in dosage, or even discontinuation, of other antihypertensive drugs may be necessary.

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Dean's Page

A Paradox

William B. Deal, M.D.

In 1977, the United States finds itself rapidly approaching a situation which is unique in this century. There is an astounding number of physicians being licensed in the United States in contrast to a relatively stable population growth nationwide. Ten years ago, there was a shortage of 50,000 physicians as estimated by the Department of Health, Education, and Welfare. This estimate was in absolute numbers and did not consider distribution or specialty of the physician.

Approximately at the same time, the number of qualified applicants to medical school began to rise. This increase accurately reflected the increase of birth rate during the 1940s. Simultaneously, Congress passed the Health Manpower Act of 1971 which monetarily encouraged existing medical schools to increase enrollment. Other federal grants encouraged the establishment of new medical schools which resulted in over 30 new schools. Consequently, in 10 years, the number of graduates from U.S. medical schools has increased from approximately 7,500 to more than 15,000 in 1977.

Also, the number of foreign medical graduates entering the country and obtaining licensure (excluding our Cuban exile colleagues) increased drastically. The Health Manpower Act of 1976 will reduce the number of foreign medical graduates entering the U. S. on a permanent visa but has required medical schools receiving capitation money to increase their enrollment even more! In short, the "pipeline" has not only increased in diameter but the input pressure has increased. The "pipeline" is now full and suddenly, our national leaders have recognized a predictable phenomenon — a surplus of physicians.

Other events have taken place in the past 10 years which have increased the complexity of the

problem. In seeking a new role, the nursing profession embarked on a more independent one. The advent of the "nurse practitioner" resulted. Pharmacy, for decades a compounding and dispensing practice, embarked on a "clinical" course with programs developed to become "clinically relevant". Indeed, in 1977, the trend is toward two new professional degrees being awarded by an increasing number of academic institutions — Doctor of Nursing and Doctor of Pharmacy. Each holder of those degrees, expects to be intimately involved in the management of the sick and thus, a changed role from previous years. Physician Assistant programs evolved also as an extender of health care under the aegis of a licensed physician.

The absolute increase of health professionals plus inflation has resulted in an increase in higher personnel costs which are 50% of the average hospital budget. Plus, the utilization of these professionals has increased the need for more support personnel. Now the minimum wage will increase by 45% by 1981 which will trigger a wage spiral across the board.

Congress is acting in a contradictory manner by attempting to contain hospital costs by regulating the annual increment increase of hospital charges to only 9%. While on the other hand, a generous minimum wage increase has been mandated. A paradox exists!

The Declaration of Independence declares "Governments derive their just powers from the consent of the governed." Jonathan Swift stated: "All government without the consent of the governed, is the very definition of slavery." The "governed" professionals and the lay public must clearly transmit our concerns to Congress.

- Dr. Deal, University of Florida College of Medicine, Gainesville 32610.

Dr. Deal is Acting Dean of the University of Florida College of Medicine, Gainesville.

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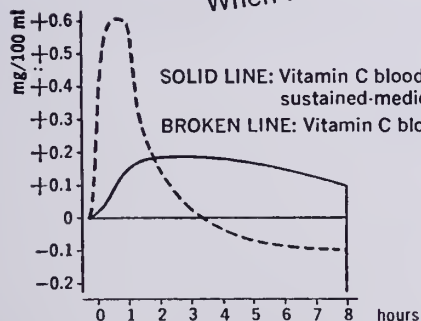
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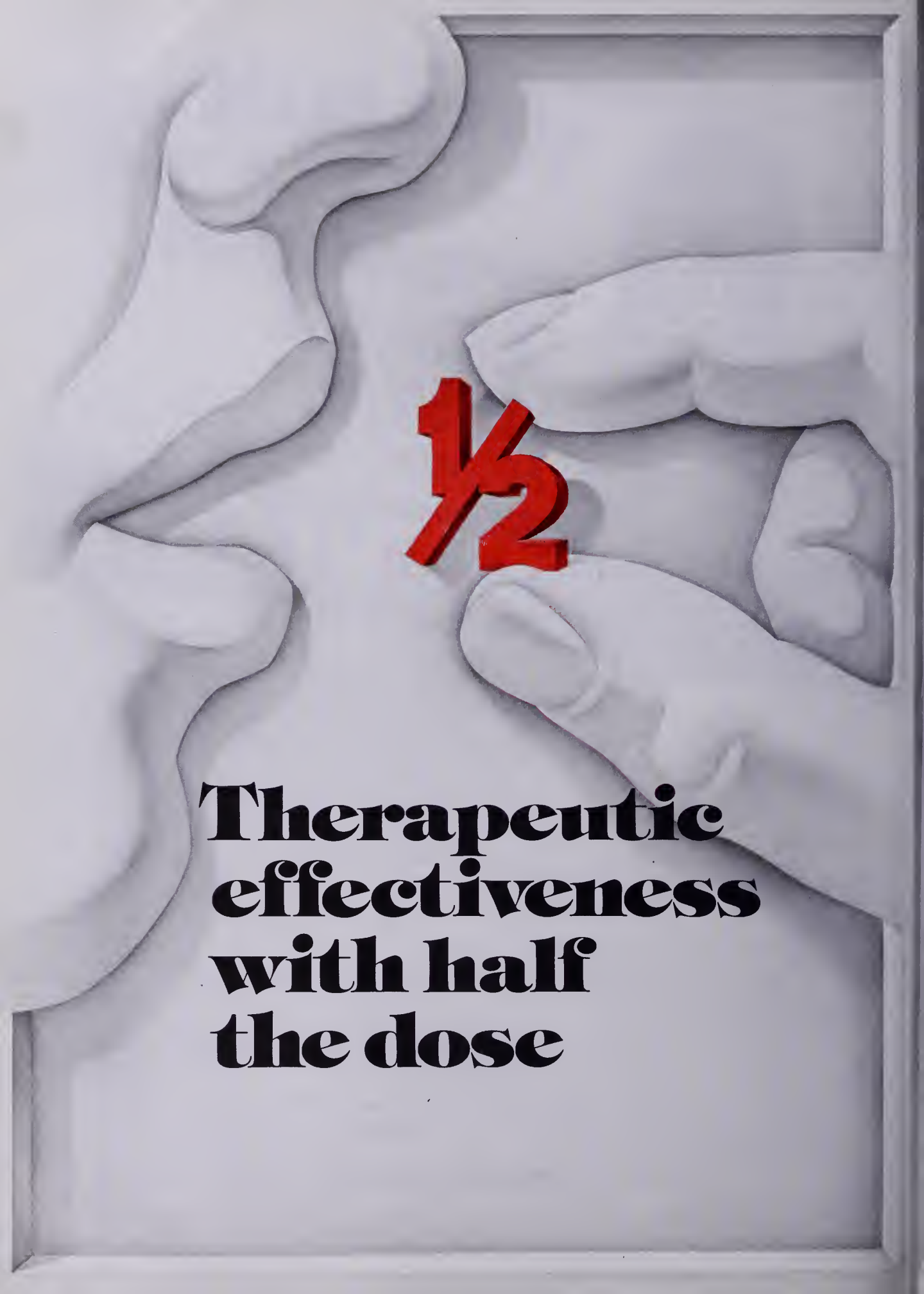
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¹ Riccitelli, M. L.: Vitamin C Therapy in Geriatric Practice, J. Amer. Geriatrics Soc. 20: 34, 1972.

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See Clinical Considerations section on following page...

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Note: Prior to therapy, the type of fungi responsible for the infection should be identified.

The use of this drug is not justified in minor or trivial infections which will respond to topical agents alone.

Griseofulvin is not effective in the following: Bacterial infections, Candidiasis (Moniliasis), Histoplasmosis, Actinomycosis, Sporotrichosis, Chromoblastomycosis, Coccidioidomycosis, North American Blastomycosis, Cryptococcosis (torulosis), Tinea versicolor, and Nocardiosis.

CONTRAINDICATIONS This drug is contraindicated in patients with porphyria, hepatocellular failure, and in individuals with a history of hypersensitivity to griseofulvin.

WARNINGS Prophylactic Usage: Safety and efficacy of griseofulvin for prophylaxis of fungal infections have not been established.

Animal Toxicology: Chronic feeding of griseofulvin, at levels ranging from 0.5-2.5% of the diet, resulted in the development of liver tumors in several strains of mice, particularly in males. Smaller particle sizes result in an enhanced effect. Lower oral dosage levels have not been tested. Subcutaneous administration of relatively small doses of griseofulvin once a week during the first three weeks of life has also been reported to induce hepatomata in mice. Although studies in other animal species have not yielded evidence of tumorigenicity, these studies were not of adequate design to form a basis for conclusions in this regard.

In subacute toxicity studies, orally administered griseofulvin produced hepatocellular necrosis in mice, but this has not been seen in other species. Disturbances in porphyrin metabolism have been reported in griseofulvin-treated laboratory animals. Griseofulvin has been reported to have a colchicine-like effect on mitosis and cocarcinogenicity with methylcholanthrene in cutaneous tumor induction in laboratory animals.

Usage in Pregnancy: The safety of this drug during pregnancy has not been established.

Animal Reproduction Studies: It has been reported in the literature that griseofulvin was found to be embryotoxic and teratogenic on oral administration to pregnant rats. Pups with abnormalities have been reported in the litters of a few bitches treated with griseofulvin. Additional animal reproduction studies are in progress.

Suppression of spermatogenesis has been reported to occur in rats, but investigation in man failed to confirm this.

PRECAUTIONS Patients on prolonged therapy with any potent medication should be under close observation. Periodic monitoring of organ system function, including renal, hepatic, and hematopoietic, should be done.

Since griseofulvin is derived from species of penicillin, the possibility of cross sensitivity with penicillin exists; however, known penicillin-sensitive patients have been treated without difficulty.

Since a photosensitivity reaction is occasionally associated with griseofulvin therapy, patients should be warned to avoid exposure to intense natural or artificial sunlight. Should a photosensitivity reaction occur, lupus erythematosus may be aggravated.

Griseofulvin decreases the activity of warfarin-type anticoagulants so that patients receiving these drugs concomitantly may require dosage adjustment of the anticoagulant during and after griseofulvin therapy.

Barbiturates usually depress griseofulvin activity, and concomitant administration may require a dosage adjustment of the antifungal agent.

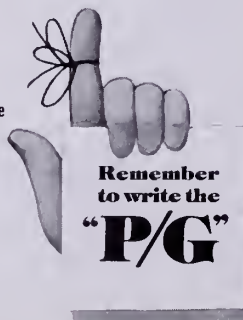
ADVERSE REACTIONS When adverse reactions occur, they are most commonly of the hypersensitivity type, such as skin rashes, urticaria, and rarely, angioneurotic edema, and may necessitate withdrawal of therapy and appropriate countermeasures. Paresthesias of the hands and feet have been reported rarely after extended therapy. Other side effects reported occasionally are oral thrush, nausea, vomiting, epigastric distress, diarrhea, headache, fatigue, dizziness, insomnia, mental confusion, and impairment of performance of routine activities.

Proteinuria and leukopenia have been reported rarely. Administration of the drug should be discontinued if granulocytopenia occurs.

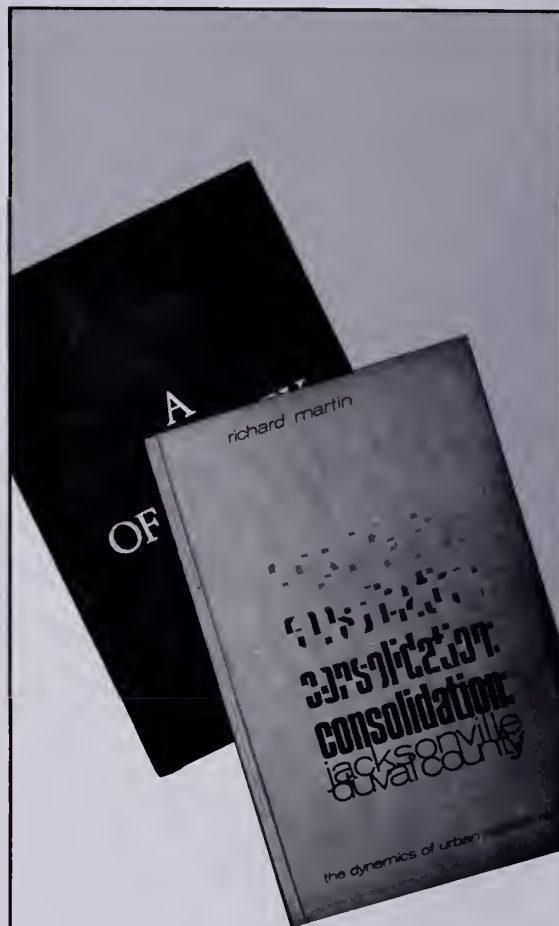
When rare, serious reactions occur with griseofulvin, they are usually associated with high dosages, long periods of therapy, or both.

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FROM THE EDITOR'S DESK

MEDICAID SURGERY

The House Subcommittee on Oversight and Investigations is puzzled by data it has collected on Medicaid surgery. In a recent report, the Subcommittee said "it is difficult to believe" that Pennsylvania reported 60,000 Medicaid surgical procedures in 1975 and 379,772 in 1976, an increase of more than 500 per cent. Figures also indicated that in Virginia, such procedures dropped from 52,000 to 22,480 in the same period. "What the report really reveals is that the Medicaid program is nothing less than an administrative horror," observed Robert B. Hunter, M.D., Chairman of the AMA Board of Trustees. "They (the data) undermine what little confidence there may be that Medicaid is managed with anything resembling an acceptable level of efficiency."

* * * *

ANTI-TRUST CASE

The Federal Trade Commission's anti-trust case against the AMA is expected to last five and a half months. It began before an administrative law judge in Washington in September. FTC plans to call 40 witnesses and present 600 exhibits.

* * * *

RESUSCITATION TRAINING

The AMA is planning to co-sponsor with the national Jaycees a national program in cardiopulmonary resuscitation training. Under the proposed program, several Jaycees in each state would receive CPR instruction. They would train other members and the public.

* * * *

TV VIOLENCE

The AMA has continued its campaign against television violence with a \$30,855 grant to the National Citizens Committee for Broadcasting. The funds supported the Committee's 13-week monitoring of programs during the fall.

CUTANEOUS TOXICITY

Papers presented at a symposium sponsored by the Society of Toxicology in cooperation with the AMA have been published in a new book, **Cutaneous Toxicity**. Topics include safety evaluations, cutaneous and percutaneous absorption, irritancy and sensitization, and systemic toxicity. Copies may be purchased for \$14.50 from Academic Press, 111 Fifth Avenue, New York, N.Y. 10003.

* * * *

COST SAVING "INITIATIVES"

The Catholic Hospital Association has termed "despicable and inhuman" two proposals suggested by the Health Care Financing Administration to reduce health costs. The "ideas" were suggested to HEW Secretary Califano by HCFA Director Robert A. Derzon. One would encourage states to pass "living wills" legislation which presumably would reduce expenses for geriatric care. The other concept is the coverage of abortions under Medicaid. The Catholic Hospital Association letter to President Carter called for Derzon's resignation and a public denouncement of his proposals.

* * * *

NHI IN CANADA

A study shows that morbidity and mortality statistics appear unchanged since Canada went into national health insurance. The study, conducted by the National Center for Health Services Research, stated that the Canadian government does not appear to be able to contain health costs, but access to care seems to have improved at all income levels.

* * * *

The Editor

THIRTEENTH ANNUAL POSTGRADUATE COURSE

"INTERNAL MEDICINE 1978"

February 5 - 10, 1978

Fontainebleau Hotel,

Miami Beach, Florida

Directors: William J. Harrington, M.D., Eric Relss, M.D., and Neal S. Bricker, M.D.

Program Coordinator: Jose S. Bocles, M.D.

The object of this course, the thirteenth in its series, is to provide an annual updating of the most useful recent advances in the diagnosis and management of internal medical disorders as they are encountered by primary care physicians and practicing specialists.

GUEST FACULTY

Joseph B. Kirsner, M.D., Louis Block Professor of Medicine, The Pritzker School of Medicine; Chief of Staff and Deputy Dean for Medical Affairs, The University of Chicago Hospitals and Clinics, Chicago, IL.

Bernard Lown, M.D., Professor of Cardiology, Harvard University School of Public Health, Boston, MA.

Gene H. Stollerman, M.D., Professor and Chairman, Department of Medicine, University of Tennessee, College of Medicine, Memphis TN.

John H. Vaughan, M.D., Chairman, Department of Clinical Research, Scripps Clinic and Research Foundation, La Jolla, CA.

HIGHLIGHTS

State of the Art Lectures

Each subspecialty will be introduced by a State of the Art Lecture given by a distinguished authority.

Meet the Faculty Sessions

These sessions will consist of simultaneous small meetings in which illustrated aspects of each subspecialty will be presented followed by open discussions of topics not formally reviewed in the lectures.

Ladies Activities

An extensive program will be offered.

Learning Center

The Learning Center consists of fully automatic synchronized cassette/slide projection of lectures. This center will be available during the evenings.

Audio Visual Aids

Audio visual teaching aids (television sets with tape players, slide projectors synchronized with cassette tapes and guides) will be available during the entire meeting for self instruction and reinforcement.

Exhibits

Scientific and Technical Exhibits will be shown daily.

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*Letter from Chief of Service must accompany registration.

For Registration and Information write to: J. Bocles, M.D., Department of Medicine, University of Miami School of Medicine, P.O. Box 520875, Miami, Florida 33152. Phone: (305) 547-6063.



PICTORIAL HIGHLIGHTS OF THE FALL BOARD MEETING

October 4-9, 1977

Top Row: FMA Executive Vice President W. Harold Parham, D.H.A., and President Louis C. Murray, M.D., Orlando; AMA Delegate James T. Cook, M.D., Marianna; and Charlotte Behrman, M.D., Department of Health and Rehabilitative Services, Tallahassee.

Second Row: AMA Delegate Richard G. Connar, M.D., Tampa; George S. Palmer, M.D., Executive Director of the State Board of Medical Examiners, Tallahassee, and James F. Richards, Jr., M.D., Orlando, Chairman of the Council on Medical Economics; AMA Trustee Jere W. Annis, M.D., Lakeland, and AMA Delegate Samuel M. Day, M.D., Jacksonville.

Third Row: AMA Delegate Joseph C. Von Thron, M.D., Cocoa Beach; Board Member Donald G. Nikolaus, M.D., Dunedin; Mrs. Richard B. Moore, West Palm Beach, President of the FMA Auxiliary; Board Members Edward Stoner, Oviedo, and Benjamin M. Cole, M.D., Orlando; and House Speaker Charles J. Kahn, M.D., Pensacola.

Others Are Saying

HEW Goofs . . . And Wronged Physicians Pay

James Kilpatrick

A month or so ago, the Department of Health, Education and Welfare released some titillating figures to the press: Approximately 400 American physicians had raked in more than \$100,000 from Medicare payments in 1975, and 16 of the doctors had ripped off the taxpayers for upwards of \$250,000.

The release, to be sure, did not use such verbs as "raked in" and "ripped off," but these were the clear implications. Inevitably the data suggested that physicians and surgeons were profiteering off a great, humanitarian program.

This was the universal interpretation. One cartoonist imagined two surgeons operating on a Medicare patient. "Go on, Joe," says one, "cut on down to the \$5,000 layer."

As it swiftly transpired, HEW's facts and figures were wrong. The errors were not few and small. The errors were numerous and massive. This was wholesale error — error on a grand scale — error to be marveled at.

Of the 16 top rip-off artists, those identified with earnings of \$250,000 or more, HEW had its facts wrong as to 14. That is an error rate of .875. A shortstop who muffed seven grounders out of eight could not stay long even in the bush leagues.

The American Medical Association managed to query 208 of the 407 identified physicians. It turned out that HEW was wrong as to 135 of them. HEW reported, for example, that Dr. Cem A. Bayar of Chicago received \$258,139 in 1975; trouble was, Dr. Bayar died in 1974.

HEW reported that Dr. Ernest Watson of Elmhurst, Ill., received \$233,871 in 1975; trouble was, Dr. Watson, a pediatrician, retired in 1965 and moved to Arizona.

In more than a hundred cases, the HEW disclosures dealt not with individual physicians, but with groups and clinics. Starting at the top, HEW identified a New York doctor as Number One, with earnings of \$412,757; the figure was for a group of physicians.

Number three on the list, with \$315,454, actually was a group of four internal medicine specialists. A doctor in Rhode Island reportedly raked in \$307,452; this doctor is in fact a salaried staff member of a hospital. His personal Medicare earnings amounted to \$625 only.

So it went, on down the incriminating list. The named doctors suffered immediate abuse. Dr. J. C.

Pruitt of St. Petersburg sent the American Medical Association a sample of letters he had received denouncing him as a "medical paracite" (sic) and a "disgrace to the medical profession" who should make amends to "those poor souls that you have robbed."

Other doctors complained that publication of the erroneous data set them up as targets for kidnapers and burglars.

A press spokesman at HEW explains defensively that Secretary Califano didn't intend to embarrass anyone, and didn't release the figures voluntarily. It appears that an amendment to the Freedom of Information Act became effective on March 12.

A number of reporters had asked for the figures on Medicare payments to doctors. Califano therefore had no choice. He fed the hungry reporters the figures for release on March 14.

Besides, says the HEW spokesman, the error wasn't exactly human error. This was "computer error." The input was wrong. This is diagnosed in computer practice as the GIGO syndrome: Garbage In, Garbage Out. A corrected list is now being prepared, and will be released as soon as it is ready.

Alas, as all of us in the news business know, the truth will never catch up with the falsehood. Truth plods along in walking boots, while error runs on winged feet. The doctors who have been effectively libeled will go to their graves with a taint of greed still clinging to them.

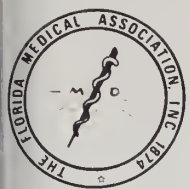
I say "effectively libeled" as distinguished from actually libeled, for the doctors have no recourse at law against Secretary Califano. If HEW's Medicare spokesmen acted with reckless disregard for the facts, which they did, this is tough stuffsky; sorry 'bout that.

The government has a kind of sovereign immunity in these matters. The computers' errors were inhuman; they were also divine.

The whole business is regrettable. The individual doctors are hurt. Their profession suffers. We of the press gain nothing; we were unwitting conduits of error.

HEW's reputation for credibility is damaged. Who will believe the next set of government "facts"? Everyone is sorry, but make no mistake about this: It will happen again.

Reprinted from the Florida Times Union, Jacksonville, April 21, 1977. Mr. Kilpatrick is a syndicated columnist (Copyright 1977, Washington Star Syndicate, Inc.)



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W. Harold Parham, D.H.A.
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November 21, 1977

The Honorable Bill Gunter
Office of Treasurer
Insurance Commissioner
State of Florida
Tallahassee, Florida 32304

Dear Commissioner Gunter:

Enclosed is our filing for the professional liability insurance rates for the Florida Physicians' Insurance Reciprocal for 1978. In reviewing these rates, you will notice an increase for the third-year and second-year claims-made member, while the first-year claims-made member will pay approximately the same as a new member in 1977. This increase in rates, however, will be decreased by a dividend to all policyholders of record December 1, 1977, payable December 31, 1977, which has been approved by the Board of Directors of the Florida Physicians' Insurance Reciprocal on November 17, 1977.

A dividend for these policyholders will amount to 7.35 percent of their proposed premiums which will, in effect, reduce the increase of premiums for the third-year claims-made member to 18.23 percent of the 1977 rates and to 20.2 percent for the second-year claims-made member over the 1977 rates. This dividend has been made possible because of the good loss experience which the FMA-PLI-Trust and the Florida Physicians' Insurance Reciprocal have experienced as a result of tort reforms enacted by the Florida Legislature during 1975, 1976, and 1977, as well as the aggressive defense of all nonmeritorious claims and because of good management of the fund.

I am happy to report that the Florida Physicians' Insurance Reciprocal is in good financial condition and that the sum of \$6,051,000 has been set aside as surplus based on an anticipated gross premium of \$27,227,000 for 1978 and a total net premium of \$18,152,000 (after cost for reinsurance), resulting in a premium to surplus ratio of 3 to 1.

The success of the FMA-PLI-Trust and the Florida Physicians' Insurance Reciprocal has been noted by our reinsurers in London, and as a result, we have been able to obtain reinsurance at a reduced percentage over the previous two years, and in addition, we are not required to escrow premiums for 1978 as premium security deposit, for the two years will be utilized for the three-year period.

In summary, we feel that the professional liability crisis in Florida has peaked, and we are looking forward to the coming years with eager anticipation toward continued relief for the physicians and their patients in the State of Florida from the previous spiraling cost of providing professional liability insurance.

Very truly yours,

W. Harold Parham, D.H.A.
Attorney-in-Fact

Enclosure

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Ruptured Ectopic Pregnancy in an Ectopic Tube First Case Report

Victor Dabby, M.D. and Robert Nardone, M.D.

ABSTRACT: A case is reported of a ruptured ectopic pregnancy in an ectopic tube. Surgical and pathological findings are presented with photographic documentation. A computer review of the literature failed to document a similar case.

Report of Case

A 34-year-old white woman gravida 4 para 2 was admitted in February 1976 to South Miami Hospital because of abdominal pain. She was treated conservatively for three days with antibiotics and intravenous fluids. Pain and tenderness persisted in the right paraumbilical and right subhepatic regions. A pregnancy test was negative. Progressive signs of peritoneal irritation developed with a concomitant drop in hemoglobin. A pelvic examination showed no abnormalities. The patient was taken to surgery. An exploratory laparotomy was performed by making a midline suprapubic incision. The operative findings were interesting and quite baffling. A normal uterus with a normal left tube and ovary was found. There was a complete absence of the right tube and ovary. A scant amount of old blood was found in the pelvis. Noting that this patient had never had previous abdominal surgery and, in order to identify the source of her complaint, the incision was extended cephalad in a right paramedian fashion. A mass composed of a hemorrhagic distended tubular structure situated lateral to the ascending colon and reaching cephalad to the right subhepatic region was found (Fig. 1). The right kidney and ureter were absent. A fibrous cord about 0.5 cm in diameter

extended over the brim of the right pelvis to the right subhepatic region and into the mass. In spite of this unusual finding a tentative diagnosis of a ruptured ectopic pregnancy in an ectopic tube was made. The mass was resected, care being taken not to compromise the blood supply of the right colon, injure the duodenum, or remove a small ovarian like structure. The postoperative course was uneventful.

Pathologically the tumor consisted of an ectopic fallopian tube with no apparent connection to a uterus, acute and chronic salpingitis, and hematosalpinx. The latter was confirmed as an



Fig. 1.—Fallopian tube showing ruptured pregnancy lateral to cecum.



Fig. 2.—Right ectopic tube.

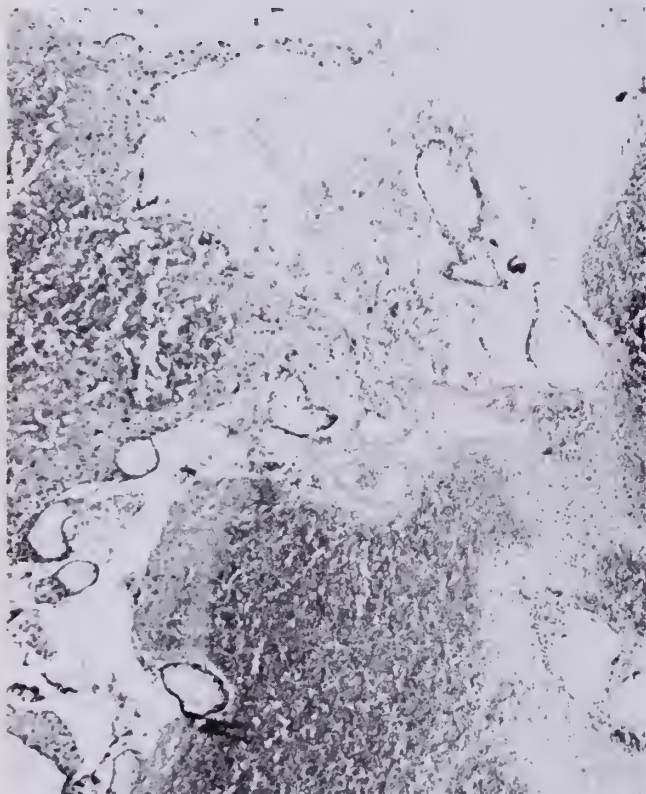


Fig. 3.—Placental villi from ruptured right ectopic tube.

ectopic pregnancy (Figs. 2, 3). A subsequent intravenous pyelogram revealed absence of the right kidney with compensatory hypertrophy of the left kidney and ureter (Fig. 4).

Discussion

A computer search of the literature failed to reveal a case of ruptured ectopic pregnancy in an ectopic tube. The incidence of tubal pregnancy is



Fig. 4.—Intravenous pyelogram showing absence of right kidney.

generally quoted at about one in 300 pregnancies. The occurrence of an ectopic tube is rare. Ruptured ectopic pregnancy in an abnormally located tube is exceedingly rare and to our knowledge has not previously been reported.

In a discussion and analysis of our case, we note that despite the abnormal location of the right adnexa, the microscopic analysis of the specimen demonstrates a normal histologic pattern. The right fallopian tube, although it failed to displace laterally and inferiorly, developed in a normal fashion together with the right ovary. During laparotomy the right adnexa were found in the original medial paravertebral embryologic locus of origin. The events leading to conception are more easily comprehended than the embryological aspects of the case. Presumably the sperm transmigrated through the peritoneal cavity from the normal left salpinx to be picked up by the fimbria of the ectopic right salpinx, which contained the ovum from the adjacent right ovary. Some fimbria . . . Some sperm . . .

Acknowledgement is due Ms. Jane Rich for research of this topic.

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- Dr. Dabby, 2506 Ponce de Leon Boulevard, Coral Gables 33134.

Patent Ductus Arteriosus in a 74-Year-Old Woman

Carlos M. Estevez, M.D.

ABSTRACT: A case report is presented of a woman who lived to age 74 years with undiagnosed patent ductus arteriosus. Her remarkable clinical history included several surgical stresses throughout her life without major cardiovascular complications. The murmur of patent ductus repeatedly had been misinterpreted as due to aortic stenosis and insufficiency. The correct diagnosis ultimately was made on clinical grounds and verified by cardiac catheterization.

Patent ductus arteriosus is a congenital lesion usually discovered during childhood. Scattered case reports of elderly patients with patent ductus arteriosus have been published in the literature during the past three decades.¹⁻⁴ This report presents the clinical features of a woman who has survived to age 74 years with a patent ductus.

Case Report

The patient was referred for cardiovascular evaluation. She had experienced no significant symptoms until December 1975 when she noticed onset of exertional dyspnea and fatigue without associated chest discomfort, orthopnea, paroxysmal nocturnal dyspnea or ankle swelling. She gave a history of having a "heart murmur" since at least age 20. She had no history of rheumatic fever as a child, but had carried a diagnosis of "rheumatic aortic stenosis and insufficiency" for many years. The past medical history included a hospitalization during her early 20's in a sanatorium for treatment of pulmonary tuberculosis where a left pneumothorax was performed as part of the treatment. She had a subtotal thyroidectomy in her 40's for "thyrotoxicosis". A cataract was surgically removed at age 65, and a cholecystectomy was performed at age 68 years. The family history indicated no known congenital heart disease or maternal rubella. She had no prolonged exposure to high altitudes after birth.

Physical examination revealed a well-developed, elderly lady in no acute distress. The blood pressure was 170/70mm Hg. The radial pulse was 80/mm and regular. Respirations were 20/min. The carotid and peripheral arterial pulses were bounding. The chest was deformed by marked levoscoliosis of the thoracic spine. There was diminished excursion of the left hemithorax. The breath sounds were decreased over the left lung field but clear on the right. Cardiac examination disclosed a systolic thrill palpable at the 2nd and 3rd intercostal space at the midclavicular line. The apical impulse was hyperdynamic, located at the 6th intercostal space just beyond the midclavicular line. A grade IV/VI, harsh, continuous murmur was best heard over the area of the palpable thrill. The murmur peaked in late

systole and extended throughout diastole in a decrescendo fashion. The systolic component of the murmur radiated throughout the precordium. The diastolic component radiated along the left sternal border. The 2nd sound was single. No gallops were heard. The liver was not enlarged. The extremities showed no clubbing, cyanosis or edema.

The chest radiograph (Fig. 1) disclosed fibrocalcific lesions of the left hemithorax and decreased left lung volume, consistent with past granulomatous disease and residual fibrothorax. The cardiac silhouette was displaced to the left and appeared enlarged. The proximal pulmonary vessels were very prominent. The appearance of the chest radiograph had not changed since, at least, 1970. The electrocardiogram disclosed regular sinus rhythm and nonspecific ST-T wave changes. The precordial voltage suggested left ventricular hypertrophy.

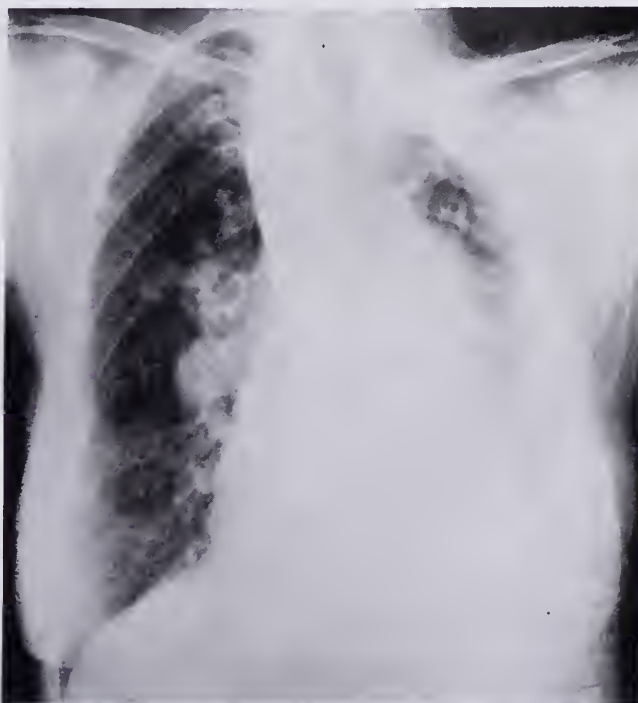


Fig. 1.—Chest radiograph showing fibrocalcific densities of the left hemithorax, diminished left lung volume and prominent proximal pulmonary vessels.

The clinical impression was patent ductus arteriosus in a patient with restrictive lung disease due to old tuberculous disease. Cardiac catheterization was recommended and carried out.

At the time catheterization, the venous catheter showed the characteristic passage from the pulmonary artery across the patent ductus into the descending aorta (Fig. 2). No calcification was noted across the defect. A 1.9 to 1 left to right shunt at the level of the pulmonary artery was demonstrated. The left ventriculogram disclosed a slightly thickened left ventricle with excellent contractility. There was no evidence of a ventricular

septal defect. Contrast material injected into the ascending aorta traveled across the arch and promptly filled a massively dilated pulmonary artery. There was no significant aortic or pulmonic valve insufficiency. The resting left ventricular end diastolic pressure was at the upper limits of normal (12 mm Hg). The main pulmonary artery pressure was mildly elevated (24 mm Hg). The pulmonary vascular resistance was normal. There was no gradient across the aortic, mitral or pulmonic valves. The relevant catheterization data is presented in Table I.

Table 1.—Cardiac Catheterization Data

	Oxygen		Pressure mm Hg
	Saturation %	Volume %	
Superior vena cava	68	12.3	
Right atrium	66.5	12.0	(6)
Right ventricle	75	13.6	35-44/5-9
Main pulmonary artery	80	14.5	32-44/12-18 (24)
Pulmonary capillary wedge			(13)
Left ventricle			168/12
Ascending aorta	95	17.2	174/56 (136)
Oxygen capacity		18.1	
Oxygen Consumption		189.9 cc/min.	
Pulmonary blood flow	7 L/min.		
Systemic blood flow	3.68 L/min.		
Left to right shunt	3.32 L/min.		
PBF/SBF	1.9/1		
Pulmonary vascular resistance	126 dynes/sec./cm ²		
Hemoglobin	13.5 gms.		

Figures in parenthesis indicate mean pressure



Fig. 2.—AP fluoroscopic view of the chest showing the characteristic passage of the venous catheter from the pulmonary artery across the patent ductus into the descending aorta.

In view of the advanced age, the complicating fibrothorax, the fairly well compensated left ventricular hemodynamics, and reasonably well tolerated symptoms, it was elected to manage the patient medically without surgical correction of the defect.

Discussion

Patent ductus arteriosus is a condition rarely encountered in elderly patients. It is generally accepted that the normal life span is significantly shortened in these patients. Nevertheless, scattered case reports have appeared in the literature of patients surviving into their 7th and 8th decades. Congestive heart failure, pulmonary hypertension and bacterial endocarditis are the dreaded complications of untreated patent ductus arteriosus. Our patient is remarkable in that she sustained major surgical stresses and a "therapeutic" lung collapse and managed to avoid complications. At age 74 years she maintains normal resting left ventricular end diastolic pressure and normal pulmonary vascular resistance.

The misinterpretation of the murmur of patent ductus for aortic insufficiency has been pointed out by other authors.^{5,6} Our patient carried the erroneous diagnosis of "aortic stenosis and insufficiency" for many years. Careful auscultation at the 2nd and 3rd intercostal space toward the midclavicular line disclosed the characteristic enveloping of the 2nd sound by the continuous murmur. Her case illustrates that the possibility of a patent ductus should be kept in mind in elderly patients with diastolic murmurs thought to be due to aortic insufficiency.

The surgical correction of the uncomplicated ductus is usually recommended in young patients because at low surgical risk complicating problems such as bacterial endocarditis, pulmonary hypertension and congestive heart failure can be eliminated. On the other hand, the decision as to when to operate in the elderly patient is not so well defined. Our patient and others reported in the literature are examples of long survival, free of cardiovascular complications.

This case report illustrates that elderly patients with patent ductus arteriosus are encountered in clinical practice. The lesion can be reasonably well tolerated for many years and correctly identified by careful physical examination.

Acknowledgment

Cardiac catheterization was performed by Dr. Sheldon S. Sbar, Director of the Cardiology Center, Tampa General Hospital, who kindly provided the data described in this report.

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- Dr. Estevez, 501 Eleventh Street North, St. St. Petersburg 33705.

Health Care in Correctional Facilities

Joseph A. Baird, M.D.

This report is a brief summary of a project supported by Title IX, Public Health Service Act; however, the findings, conclusions and recommendations are those of the author and do not necessarily represent the views of the United States Public Health Service. The full report may be obtained from the author or from the Southern Health Foundation, Inc., 551 Executive Drive, Suite 233, Tampa, Florida 33609.

In the summer of 1972 Mr. Emmett Roberts, who was then the Secretary of Health and Rehabilitative Services, authorized Dr. Wilson Sowder, State Health Officer, to make a survey, by questionnaire, of the health services available at all short-term penal institutions in Florida—facilities wherein confinement did not normally exceed one year. A few months later the survey was completed. It was published in the March 1975 issue of the Journal of the Florida Medical Association under the title, "Health Services at City and County Jails, Stockades, and Youth Detention Centers in Florida." It became known as the Stinger, Johnson, and Sowder Report, named for the authors who compiled the data, analyzed it, and presented it. The last paragraph of that report pointed out certain things that needed to be done if jail health was to be improved and those remarks served to catalyze the actions leading up to this paper which, although it was done under different sponsorship, in a different way, with a different project director and author, can be considered as an extension of the work reported upon by the other authors. They cannot, of course, be held liable for the findings, opinions and recommendations now being presented.

Attempts to improve the lot of the prisoners are not new. The first Model Rules for English Prisoners nearly 200 years ago required the doctor "to visit the patients every day, examine every person on admission, see every prisoner at least once per week, inquire into the state of his body and mind" and so on. In our time, standards and guidelines for care of inmates of jails and prisons have been written by the United Nations, National Advisory Commission on Criminal Justice Standards and Goals, American Correctional Association, American Academy of Pediatrics, National Sheriffs

Association, and many other supervisory bodies including the state of Florida.

In October 1972 the Director of the Florida Regional Medical Program, Inc., Granville W. Larimore, M.D., and his staff showed an active interest in studying the delivery of health care in Florida detention facilities, specifically in short-term penal institutions (STPI's) and in youth detention centers (YDC's). The STPI's used in this study were county jails, stockades and work camps—no city jails. Planning, writing and searching for a project director took nearly two years. During this time there were several conferences between Dr. Larimore and representatives of the State Department of Health and Rehabilitative Services on such matters as how to actually determine health care needs; how to observe current jail practices, roles, responsibilities, and recommendations for improvement of quality, where appropriate.

The final agreement provided that the Division of Corrections would designate the jails to be observed and would obtain local cooperation; the Division of Youth Services would select the youth detention centers to be observed; the Division of Health would be the action agency, and the FRMP would provide money, operational supervision, staff support and office space for the project director. The project which began on 1 December 74 was limited to seven months, too short a time and too little money and staff to make a serious study of the problem. The director had no staff except for the part-time use of any one of the office stenographers who might be available. After a few months the staff was augmented by the half-time assistance of Marcia Claussen R.N., M.A., who served as project coordinator, and by the half-time services of one typist. The project was then funded and authorized for a total of 19 months. The director appointed a Project Advisory Committee of prominent citizens who represented interested organizations and then sent a Memorandum of Understanding to each participating sheriff or supervisor.

The Memorandum was written to formalize the verbal agreements made earlier. Pertinent portions of it are:

The Project Director agrees

To notify the sheriff or supervisor, as

Dr. Baird is Assistant Medical Director of the Hillsborough County Jail in Tampa. He formerly served as Project Director for the Florida Regional Medical Program, Inc.

appropriate, of a planned visit.

To conform to the rules, regulations and security provisions of each site visited.

To respect the confidentiality of all findings and to make no public comment on anything witnessed in any institution.

To safeguard the identity of all records and procedures observed.

To avoid relating any particular data to any one institution, and to adhere to the principle that the jail or center being studied is not being studied for itself alone but simply as a model of an institution of a certain size in a certain location.

The sheriff or superintendent of the subject correctional facility agrees

To permit access of the project director and his staff upon proper identification.

To cooperate in providing information that the project staff might require, such as organization, facilities, rules and policies, medical records and reports, conformance to accepted standards, and outcomes.

To provide data on rated capacity, average census, kinds of offenders, kinds of offenses, average length of stay, and such demographic data as needed for analysis and planning.

It was clear to the staff, Committee and sheriffs that this project was not a research study in depth but was, instead, an analysis of actual conditions made by trained observers to be followed by a demonstration of certain improved procedures to the extent that time and money permitted. The uncertain future status of FRMP during that time severely limited the scope of the study. A more detailed and scientific approach to include full implementation of medical intake screening, standardization of medical records, and developing and testing of model health care situations would require funding and staffing in quantity for an estimated three years, and the knowledge in advance that sufficient time and money would be provided.

The institutions chosen for study were the county jails in Hernando, Hillsborough, Pinellas and Sarasota counties, the stockade in Polk County, and youth detention centers in Manatee and Pinellas counties. In order to obtain a larger sample of different size jails in diverse locations, visits were made to and health care practices observed in a total of 29 detention facilities in 19 counties, roughly one third of the total in Florida. In addition to those listed in the basic group, there were the county jails in Alachua, Bradford, Collier, Dade, Duval, Dixie, Glades, Lafayette, Lee, St. Johns and Suwannee

counties; plus the Florida School for Boys at Okeechobee and the Lancaster Youth Development Center near Trenton. We were thus able to see and learn from two short-term YDC's which hold youths for a period less than one month; two long-term youth schools which hold youths from one to four years; and, 20 county adult detention facilities which normally hold adults less than one year. Although observations were made at youth facilities operated by the state, those findings and recommendations are not reported here. This paper is limited to county adult detention facilities.

The objectives of the Project were to learn as much as possible about the health care needs of detainees, observe how those needs were being met, find out what conditions hindered the provision of first-class health care, ascertain the health care resources available to each facility of whatever size in urban or rural locations, detect deviations from the ideal—theoretical shortcomings, develop and test a model for each size jail in whatever location, and make recommendations for broad solutions to the problems of giving adequate care.

G. O. W. Mueller, Professor of Law at New York University, has said that "The Law requires us to presume that the detainee is innocent until convicted by a court of competent jurisdiction. It also says in effect, that he is being detained solely because he lacks funds to make bail.

Consequently, logic and equity dictate that the detainee must be given as much freedom as the accused man who makes bail—limited only by the necessity for him to be detained."

Warren E. Burger, Chief Justice of the United States Supreme Court stated: "When a sheriff or marshal takes a man from a courthouse in a prison van and transports him to confinement for two or three years, this is our act. We have tolled the bell for him. And, whether we like it or not, we have made him our collective responsibility. We are free to do something about him, he is not."

In this study, the adults were in county operated facilities, and they were thus wards of the people of the county in which they were confined. County government is by definition parochial. Taxes are collected from the residents and are spent by the county commissioners for the benefit of all who may be in that county, according to need, demand, and political urgency. Not all of the inmates of a county jail are residents of that county—or even that state—and they do not therefore represent a significantly influential political force, nor are they seen by the taxpayers to be a cause for close personal concern or responsibility. On the one hand, as said by U.S.

District Judge Frank Johnson Jr. of Alabama: "A state is not at liberty to afford its citizens only those constitutional rights which fit comfortably within its budget." On the other hand, the job of a county sheriff or supervisor of corrections is a political one and funds to operate the jails are allocated to him by the county commissioners. In this project we found that funding for operation of jails varied from county to county for many reasons, and this variability was reflected in the health care available to inmates. Although it was true that the sheriff had been given guidelines and minimum standards for health care by both the state and the National Sheriffs Associations, those guidelines and standards were considered advisory and as desirable goals if funds permitted, not as directives.

Method

The method used in this study consisted of visits by project staff, Dr. Baird and Ms. Claussen, visits by specialist consultants and a limited demonstration of medical intake screening and medical record keeping.

The project staff visits were made by appointment and were held either in the office of the sheriff or in the confinement facility or both. During a visit there was an informal talk about the purposes of the study, a question/answer period, then a walk through the areas of confinement, food services, recreation, medical and any other portions available for showing. Information was elicited on all matters considered to be important to health care but there was no obvious display of a "check-list," in order to avoid any appearance of an "inspection." The project staff then talked with assigned or contract medical/nursing personnel and where appropriate visited the doctor's office or local hospital for further discussion. After leaving the facility the predesigned check lists and summary sheets were completed while the data were still fresh. In nearly all cases responses were free, easy, cordial and uninhibited. There was genuine interest in obtaining help toward solving their problems. Additional information, either basic or current was readily obtained later by telephone, letter, or further visits.

Conclusions

Health care needs and health care availability are treated separately in this section and only as they apply to county operated facilities, not to youth detention centers or training schools which are state operated.

Health care needs of inmates are generally the

same as those of persons from comparable socioeconomic levels in the general population. The few notable exceptions are that the inmate has often neglected personal care and cleanliness, nutrition and dental care; he often has chronic pain or disability from behavior related accidental injury, and he often did not seek medical care nor heed it when it was offered unless he was given a drug he wanted. Confinement increases the number, variety, and intensity of physical complaints as well as distorts the reasons for seeking medical care.

1. Most requests for care were for conditions that existed prior to arrest; very few were caused by or were incident to confinement. The health of most improved during confinement.

2. The decision between health care needs versus wants was difficult and frequently was made by a person not trained in diagnosis.

3. Mental and emotional disturbances were common; their handling posed special problems.

4. Initial health evaluation by intake medical screening is indispensable to the early identification of all illnesses.

5. The need for improvement and standardization of medical records is a real one and, together with rapid exchange of medical information between the medical staffs of all jails, is essential to giving better care at lower cost.

6. Most jails in this report are to some extent in violation of Florida statutes relating to purchasing, storing, dispensing and disposing of medicines.

Health care was available in some degree in all facilities visited.

1. The amount available varied directly with the medical resources of the nearby community as well as the ability, willingness and resourcefulness of the jailer to carry out the prescribed treatment.

2. Medicines prescribed were not the same as medicines dispensed nor medicines taken.

3. Care provided depended on many things such as: attitudes of the public and of law enforcement officers toward punishment versus rehabilitation; appreciation by a community of the obligation to care for those unable to care for themselves; willingness to pay the price for adequate care; position of the medical unit in the jail organization; politics of county government; inconsistencies in the law, its interpretation and enforcement.

4. When providing care the jailer considered his estimate of the need, the imperative, his attitude toward the inmate, his idea of the relative need as compared with all other demands on his time, money, personnel and transportation.

5. In all except three of the facilities visited there was no real organization and system of providing care; it was simply a matter of moving from crisis to crisis on an expedient rather than planned basis.

6. In most STPI's there was no opportunity or space for energy expending recreation or useful work.

7. There was little intake medical screening at any of the jails except three. Some made inadequate attempts to screen, using untrained nonmedical persons. During this project complete screening was demonstrated at two jails.

8. Accurate diagnosis and determination of need versus want were significant health care problems in the "sick call" procedure that exists at most jails. When those factors have been satisfied most inmates can be treated where they are.

9. Medical care that is prescribed may not be provided unless there are correction officers and transportation to take the inmate where and when he needs to go to get it. Such shortages are general.

10. County health department services available to correctional institutions and used by them vary from none at all to such things as direct medical or nursing care, dental care, outpatient clinics, epidemiology, sanitary and food service inspection, and mental health.

To sum up, most correctional authorities (jailers) are doing a difficult job with a maximum of human concern and doing it well. Very little remains of the old "lock 'em up and throw away the key" attitude. The jailer is charged with forcibly detaining the inmate while at the same time providing for all his physical, mental, medical and spiritual needs, thus trying to walk the tight rope between punishment and rehabilitation. The inmate is not the ordinary office patient who pays the doctor to diagnose and treat him; he is often a manipulator who lies about his illness or magnifies his symptoms in order to get out of the cell, get attention, get out of jail and into a soft hospital bed, or wants to have his 20-year-old warts removed or his old hernia repaired or his psoriasis cured. Lacking these things he may sue, alleging poor medical care or violation of his civil rights.

Recommendations

1. There are many factors affecting the health of an inmate and thus many related professional disciplines are involved, but the primary discipline is medical care. The only person capable of having a working knowledge of all the disciplines of health care is a physician; therefore, health decisions must

be made by a health professional, a physician, and not by an administrator or warden or correctional officer. As a first step toward meeting the needs for health care each sheriff should select a physician who will serve as medical director of the jail, be responsible directly to the sheriff, and have full authority to make decisions on all matters affecting the health of inmates including health personnel matters, policies, budgeting, drug control, professional competence, records and reports. He may be full or part time, salaried or under contract. While serving as medical director the physician acts as liaison to other physicians, to other health care disciplines, and to the community at large. He can arrange for primary medical and dental care and for other consultative services to the jail and can serve on the Jail Medical Committee of his county medical society. He can stimulate better understanding of the special problems of correctional medicine by urging such education in medical school, residency, and practice, and by direct exposure to the jail clinics. He can explain the responsibility of the free citizen toward the confined.

2. As a basis for staffing, the medical needs of inmates can be satisfied by a nurse in 60% of cases, by a nurse practitioner or physician's assistant in an additional 30%, and by a physician in the remaining 10%. The RN, NP or PA would function from comprehensive standing orders, prepared by the physician.

3. An indispensable first step in health care is medical screening of the new detainee before he becomes an inmate. This initial health evaluation serves to protect the man, other inmates, and the detention authorities; it helps the medical staff to meet their responsibilities to patient and sheriff; to document legal defense; to allay charges of neglect, favoritism or discrimination; to help the really ill and those needing dental care to get attention soon; to rule out pretenders and manipulators; to protect the jail from baseless complaints or suits; to collect data for social or psychological studies; to help prepare reports to management; and to serve as the beginning of the inmate's permanent medical record. Intake screening requires skill in triage and trained professional judgment; it should be done by a doctor, nurse or physician's assistant only.

4. An attempt should be made to mass screen for early detection and treatment of mental illness, potential suicides or homicides, emotional, behavioral and serious personality disorders; this could be done by interviews, self-administered tests, or newer methods of psychometry.

5. There should be an increase in the amount

and frequency of mental health evaluation and counselling during confinement, thus decreasing the need for drugs.

6. Within the state there should be standardization of all inmate medical records so that when an inmate is transferred from one facility to another his records go with him. This will prevent costly repetition of diagnostic procedures and reduce the chances for inmates to manipulate the medical staff. Short summaries can be transmitted by electronic means or telephone; complete records can follow by mail.

7. Medical activities reports should be made regularly to management in order to improve budgeting, fiscal and personnel functions.

8. To relieve a condition that seriously increases the demand for medical care — the close, almost total, daily confinement to a small cell, lack of privacy, too intimate contact with too many diverse inmates — more attention should be paid to providing means for useful work and for indoor and outdoor recreation.

9. Another factor that makes many inmates seek medical relief, yet makes them more critical of its effectiveness and less capable of rehabilitation, is what they view as a lack of uniformity in the interpretation and enforcement of the criminal code, and the great variability in both time awaiting trial and length of sentence as between the various cities and counties in the state. Others have pointed to a need to revise the criminal code and to make justice more uniform; it is medically recommended.

10. The inspection of food service operations, hygiene, sanitation and such environmental factors as heating, cooling, lighting, noises, odors, insect and rodent control in the county jails should be a function of the county health department. Its director should be given full authority, responsibility, money and people to do these things as well as to continue to provide nutritional and dietary services and clinics for infectious diseases. His report of inspection should be made to the sheriff through the jail medical director and it should have the authority of a directive.

11a. A study should be made, probably at state level, of the entire concept of short-term penal institutions, who should be detained therein and for how long, because this subject has a great effect on the provision of quality health care to inmates. Where the jail is small and isolated so that none or very little medical care is obtainable no one should be detained more than a week, and in the medium-sized jails the inmate population should be limited to those awaiting trial, probably not longer than 90 days. The figure of one week was chosen because it

usually takes from one to seven days for the decision to be made whether the newly booked detainee is going to be released or held for trial. The exact number of days need not be inflexible; when an exception is clearly indicated the state guidelines can be modified by local judgment. The figure of 90 was chosen to allow time for court appearance and sentencing or to accommodate those sentenced to less than 90 days. At present a sentence of up to one year in the county jail sometimes forces the county jailer to try to provide necessary medical care which may be both expensive and not available locally. Sentenced inmates could be transferred to state institutions or to the largest of the county jails, an act that would assure better care for those who need it and at the same time relieve the smaller counties of the burden of trying to give good medical care on a continuing basis. Only the largest jails need in-house medical capability with round-the-clock nursing.

11b. At most of the jails visited the sheriff had responsibility for law enforcement, operation of the jail, and rehabilitation, at two, for example Alachua and Dade, the sheriff having law enforcement and a chief of corrections having the others. A state level study should consider the advisability of separating the functions statewide. For example, the sheriff could continue to have county law enforcement and the corrections chief could work for the state. This would relieve the cost of operating jails that house a large number of noncounty inmates.

12. Emphasis is again given to the fact that the opinions stated herein are those of the project director and do not necessarily coincide with official positions at state level. No other project of this size has been done in county correctional facilities in Florida; the project director feels uniquely qualified to make recommendations for improvement of health care for the inmates of Florida jails. With due recognition of the political realities that must be negotiated in order to make changes and the long lead time of probably several years before those changes can be made, it is no less essential to point the way and to define ultimate objectives.

There is no claim of absolute originality in this report but there is a coincidence of findings with another study. It is the one titled "Health Care in Correctional Institutions," funded by the Law Enforcement Assistance Administration and reported by Brecher and Della Penna in 1975. It is available from the Government Printing Office. Both they and we working independently concluded that to properly provide health care in jails and prisons it

was essential that there be an organization, that it be headed by a health professional—they preferred an administrator, we prefer a physician. They also stressed the necessity of identifying and supporting budget items related to jail health care so that these would not get lost in the general budget before reaching even the first review level. There is no suggestion that health care in state prisons is any better than at county jails, but for those long-term wards of the state it should be.

By inference, there is no actual basis to expect the results of the county jail health programs to be any better than they are now, simply by transferring responsibility to the state. There is, however, a real possibility of getting better care if there is a proper organization with a physician at the head. It is recommended, therefore, that there should be at state level a physician approved by the

Florida Medical Association. He could be designated State Health Officer, Secretary of Health, or any comparable title. He should function at the Governor's Cabinet level, have planning and budget responsibilities for all persons, facilities, equipment and supplies concerned with the public health, as well as direct line authority over county health officers, and advisory authority on all health matters in all state institutions including correctional ones. His office would publish standards, guidelines, and policies relating to health care services in county detention facilities. Unless and until there is established a central health authority the health of the citizens of Florida is in limbo.

- Dr. Baird, 701 Harbor Drive, Belleair Beach 33535.

CME Committee Accepting Applications For Scientific Exhibits

The Committee on Continuing Medical Education continues to accept applications for scientific exhibit space at the 104th Annual Meeting of the Florida Medical Association.

The meeting will be held at the Diplomat Hotel in Hollywood, May 3-7. Exhibits will be available for viewing Thursday through Saturday, May 4-6. No charge is made for scientific and educational exhibit space.

Information and application forms may be obtained by contacting Mr. Edward D. Hagan, Director of Scientific Activities, Florida Medical Association, Inc., P. O. Box 2411, Jacksonville, Florida 32203.

Our new Medical Necessity Program has two worthy goals:

(1) To help contain costs.

(2) To upgrade medical care.

This program initially identifies 28 surgical and diagnostic procedures which will not be paid routinely by Blue Shield. All pertinent claims will be reviewed for medical necessity and covered only when a clear need can be proven.

Following is a list identifying the 28 surgical and diagnostic procedures:

1. Ligation of Internal Mammary Arteries, Unilateral or Bilateral
2. Radical Hemorrhoidectomy, Whitehead Type
3. Omentopexy — Portal Obstruction
4. Kidney Decapsulation, Unilateral and Bilateral
5. Perirenal Insufflation
6. Nephropexy
7. Circumcision, Female
8. Hysterotomy
9. Supracervical Hysterectomy
10. Uterine Suspension
11. Uterine Suspension with Presacral Sympathectomy
12. Hypogastric or Presacral Neurectomy
13. Fascia Lata by Stripper — when used to treat lower back pain
14. Fascia Lata by Incision — when used to treat lower back pain
15. Ligation of Femoral Vein, Unilateral and Bilateral — when used to treat Post Phlebitic Syndrome
16. Excision of Carotid Body Tumor — when used to treat Asthma
17. Sympathectomy, Thoracolumbar, Unilateral or Bilateral — when used to treat Hypertension
18. Sympathectomy, Lumbar — when used to treat Hypertension
19. Basal Metabolic Rate — BMR
20. Protein Bound Iodine — PBI
21. Icterus Index
22. Ballistocardiogram — BCG
23. Phonocardiogram with Interpretation and Report
24. Angiocardigraphy, using Carbon Dioxide, Supervision and Interpretation Only
25. Angiocardigraphy, Single Plane, Supervision and Interpretation Only, in Conjunction with Cineradiography
26. Angiocardigraphy, Multi-Plane, Supervision and Interpretation Only, in Conjunction with Cineradiography
27. Angiography — Coronary, Unilateral, Selective Injection, Supervision and Interpretation Only, Single View unless in an Emergency
28. Angiography Extremity

This program was developed in cooperation with The American College of Physicians, The American College of Surgeons and The American College of Radiology. We ask your support in making our Medical Necessity Program 100% effective.*

*A claims review by The Florida Plan indicated that most of the procedures were already being screened for medical need and few of the services in question were being performed in Florida.



Blue Shield
of Florida

The Physician — Model 1977

E. M. Papper, M.D.

Mr. President, members of the Board of Trustees, honored guests, dedicated spouses of both sexes, and our special Silver Anniversary class:

"There is a time for all things, a time to mourn, a time to dance, a time to embrace, a time not to embrace, and nothing better than that a man should rejoice in his own works." (Democritus, Jr. — 17th Century). You are rightfully here to enjoy "your own works."

Generalizations about medical students are dangerous, however, I believe that you, the member of this year's graduating class, have a more significant generation gap with the members of the current first year class than you do with your faculty and your elders, hopefully in knowledge as well as experience. Perhaps some would think that this is a matter of degree or emphasis. I am not so sure myself. One thing most members of this graduating class do have in common with their younger successors at our School of Medicine is a genuine desire to become involved in community medicine and primary care. This interest and sense of responsibility is healthy and progressive, but I suggest to you that of equal importance is a very deep and profound commitment that all of us, as physicians, must have to two other most important objectives. The first is, as it has always been, the care of the individual patient regardless of what his medical problem is; the second is the need to believe in and to support the scientific basis of medicine. Without science we have only mindless and indifferent care to offer. We care for patients and scientific medicine, leavened with compassion, is its vehicle.

In talking with students and house officers, I have observed that their participation in social and civic matters in relation to health care takes many forms, but foremost is your desire to develop a health care system that is good for all patients and comfortable for you. I am sure that the motivation for this involvement is the fact that there still exists

serious problems of discrimination, and that the inequities of the health care system of today must be corrected. Most of you are appalled by the fact that so many people get varying degrees of care. You are indignant to hear the statements that our "system" is the best ever erected. Most of you are dismayed by the fact that our infant mortality is higher than that of 17 other countries. You are often incensed by our other shortcomings. Many are puzzled by the fact that these health problems persist despite the fact that our country spends as much or more money per capita on clinical care as any country in the world. Yet we seem to have much less to show for it in terms of the care of our American people.

On the other hand, others of you have taken the position that the present system is good and that you will "make it." But some of your younger associates are convinced that the existing system must be changed radically.

The primary goal in revamping the system of health care delivery is that it must always provide adequate health care for all our people. Upon this one point all different shades of opinion are agreed.

There are many who believe, and I share this view, that as health professionals, you will wish to enhance your capabilities by employing and using allied health professionals as well as modern technology much more effectively than you have ever seen any of us do. It is essential that we as professionals should lead in these developments. It is incumbent upon us to insure that we provide excellent care with the most modern approaches in therapies to the needs of the present and the future. We in general, as a profession, have tended to resist the help of the economist or political scientist, the sociologist, the engineer and other professionals with a variety of skills. In this respect, we have been, as I see it, very shortsighted and have failed to keep our system of health care, which is, after all, man-made by us, responsive to the demands and the needs of the future. We have utterly failed to provide high quality care to all of our people wherever they live at an acceptable cost level.

Your strong interest in social and community

This Commencement Address was delivered to University of Miami School of Medicine graduates on June 5, 1977. Dr. Papper is Vice President for Medical Affairs and Dean, University of Miami School of Medicine.

affairs surely should take into account the need to improve nutrition, living conditions, and the environment. In fact, it may very well be that these changes alone can be more effective and more important than anything specifically medical that we can do to improve the health of large numbers of people. In this respect, we also should serve as the "movers and shakers" rather than maintain a position of either apathy or of opposition.

When we become involved in these broad social issues, we sometimes tend to believe that our medical background has involved us with a special kind of knowledge in which we are able to make judgments in which others have no right to participate. Nothing, of course, can be further from the truth. The question of whether an abortion should be done and under which circumstances, whether a respirator should be turned off on a patient with severe brain damage, and similar problems involving ethical and moral considerations other than medical, is answered in consultation with experts in these other areas. We do participate in activities of this kind including the control of population. We do participate in the health care of our military forces and in wartime of our enemies. We do have the unique privilege as a profession to serve all mankind, regardless of circumstances.

Even in war, we have an opportunity and a responsibility to care for the victims of war while we, as a profession, should exercise our individual rights to oppose with all our resources the military adventures of our government when we believe them to be improper and immoral. In the matter of environmental pollution, we again have dual responsibilities: that of the citizen relating to the world around him, and the very special responsibility, as physicians, to alert the general community to the consequences of environmental damage and destruction to the health of our people. As physicians also you have the unique and serious responsibility to handle the consequences of the dramatic advances in molecular biology in which biomedical engineering now makes it possible for the first time to intervene in the control of processes which in the past have known, as Sinsheimer puts it, "only the mindless discipline of natural selection for two billion years." How will you react to the proposition that you may be able to predetermine many genetic factors in your patients and in their offspring, whereas in the past this was considered to be divine at first, and then "mindless evolution"?

It is obvious, then, how important your opportunity and responsibility will be in the practice

of medicine in countless ways and areas.

These changes and these opportunities must be accepted by you and incorporated into your work. I also feel that this is an opportunity for each of you to reaffirm a commitment to two essential aspects of your responsibility. The first of these is to continue to cultivate and emphasize the scientific basis of medical practice. Nothing you do would have any meaning without a firm scientific basis. You must be dedicated to the need for keeping abreast with the future knowledge that will be developed which will radically change your practice. A devotion to science in medicine is the only way in which this can happen. You must also recommit your thinking to the care of the responsibility to the individual patient. There is no conflict between individual care in the home or the hospital and the new concept of community medicine. These are not separate. These are just two different ways of exercising responsibility to individual patients. In the course of this kind of activity, it is necessary that you must not lose your professional skills no matter how motivated you are in the care of the community. This I think to be one of the serious problems we face. There is a failure to realize that motivation is not enough. You must have knowledge and technical skill to transmit to patient care.

There is another concern I feel compelled to address today in hope and not in criticism. I believe that the increasing difficulty of achieving the privilege of studying medicine and thereby becoming a part of a noble profession — has thrown out of focus for some, perhaps many of you, that these are fundamental principles of belief and work for all of us, including you, that must be observed and cherished.

Medicine is a taxing, tough profession, with the rewards being the opportunity of doing much that is worthwhile for others with your intellectual strength and the compassion of love. I am not convinced that either quality alone is enough. I am convinced that the love of others and the almost divine sense of dedication to the service of others has not prospered as much as intellectual growth has amongst you.

For your sakes, if you wish a life of major fulfillment, please remember that, elitists though you be, you are here to serve, to help, and to succor those who need you. It is hard to love everybody — and Hans Selye says that you cannot do it — but you must at least care, and that is a good first step.

Congratulations — warmest best wishes to the class of 1977 — a class very special to me — as our Silver Anniversary graduates.

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Cabinet Level Department of Health

A priority objective for the Florida Medical Association is the establishment of a separate State Department of Health with Cabinet rank. Achievement of this goal will require an amendment to Florida's Constitution. There are three viable mechanisms to do this:

1. Legislative enactment of an amendment.
2. Public petition for inclusion on the 1978 general election ballot.
3. Inclusion in the redraft being developed by the Florida Constitution Revision Commission.

The option of choice at this time is to advocate that the Florida Constitution Revision Commission include in its rewrite provision for a Cabinet level Department of Health. This requires a change in the Executive Article to expand Florida's present elected Cabinet by one member who would be a doctor of medicine or osteopathy and who must have been licensed to practice medicine in Florida for the preceding five years.

The current Florida Constitution requires that in 1977, and each 20 years thereafter, a Constitution Revision Commission be established. The 37-member body is to file with the Secretary of State any proposed revision to the current Constitution no later than 180 days prior to the next General Election.

In order to bring maximum effort to this task, the Board of Governors has directed that priority FMA staff assistance be given to the objective. Primary staff responsibility has been given to Mrs. Nancy Moreau, FMA legislative analyst, in coordination with Mr. Donald S. Fraser, Jr., FMA Director of Legislative Affairs. They are being assisted by FMA legislative consultants as necessary. Close liaison with members of the Commission is being maintained by assigned contact physicians.

The Commission began its deliberations on July 6 and has conducted hearings throughout the state in preparation for committee work sessions which began October 12. Committee work and completion of a draft document will be finished on January 27, 1978 with additional public hearings to follow. Any changes determined necessary as a result of the hearing will be made in time for the April 19, 1978 date for delivery to the Secretary of State.

The question of a Cabinet level Department of Health has survived the initial screening process and should be debated by the full Commission during the month of December. Key to success will be the active liaison by contact physicians and FMA staff. The final result may very well depend upon factors beyond the control of these FMA efforts. Such questions as whether Florida's Cabinet system is to be appointed or elected and whether the document will specify specific entities of government — e.g., Game and Fish Commission, Public Service Commission, etc. — will have major impact on the Department of Health question.

In his testimony to the Commission on August 31, 1977, FMA President, Louis C. Murray, M.D., noted that:

"At the time our current Constitution was written, Florida was recognized as having one of America's leading public health systems. In place was a system that could effectively cope with the health challenges of the future. The mandate in the previous Constitution was a guarantee that Florida would have a strong and viable program for the generations of Floridians to follow."

"The stature of public health has declined disturbingly. The county health units survive, but they suffer from lack of statewide coordination and strong professional leadership. Health personnel and health functions have been widely dispersed. The number and quality of

professional health personnel in the central offices and in the counties have declined through transfers, resignations, and retirement. Those remaining do not exude optimism for the future. There is no state spokesman for public health who is acknowledged as such by his professional training and specialized competence, or by his appointed position."

"Public health in Florida no longer exists as a system capable of responding rapidly and continually to the health needs of people in this state. Our public health program is no longer looked upon as one of the best in the nation."

"If we continue the breakup of this once effective mechanism, there is substantial danger that many of the "old" public health problems will reoccur with the concurrent adverse effect on our vital tourism and agricultural industries. We will continue to lose in the battle against preventable diseases — heart trouble, lung disease, etc."

Surely the physicians of Florida must unite behind this vital goal for Florida's future. — Richard S. Hodes, M.D. and Mr. Donald S. Fraser, Jr.

Editor's Note: The above editorial is the first in a series *The Journal* will publish on FMA's priorities for 1977-78.

AMA Has New Committee on Services to Young Physicians

The AMA now has an Ad Hoc Committee on Services to Young Physicians. Objectives of the 11-member group are to determine the needs of young practicing physicians in order to recommend the modification of existing AMA activities and creation of new services.



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ORGANIZATION

Dr. Jere W. Annis Is Candidate For AMA Presidency



Dr. Annis

The Florida Medical Association has announced the candidacy of Jere W. Annis, M.D., of Lakeland, for President-Elect of the American Medical Association, subject to the annual election in June, 1978.

An announcement of Dr. Annis' candidacy was mailed last month to all AMA delegates and alternate delegates by FMA President Louis C. Murray, M.D., Orlando, and James T. Cook, M.D., Marianna, Chairman of Florida's delegation to the AMA.

Dr. Annis has been involved actively in organized medicine for more than a quarter century. In 1958-59, he was President of the Florida Medical Association, and he went on to be elected three times to the American Medical Association Board of Trustees, which he has served as Vice Chairman. Prior to his election as a Trustee, he served for several years in the AMA House of Delegates.

He also has served as President of the Florida Heart Association and the American Group Practice Association.

His professional honors include the Distinguished Internist Award of the American Society of Internal Medicine (1974); and the A. H. Robins Company Award for Outstanding Community Service by a Physician.

He was a founding partner of the multi-specialty Watson Clinic in Lakeland. He is a former chairman of the advisory committee to the University of Florida College of Medicine, and a past president of the Lakeland Chamber of Commerce, the United Way, Boys Club, Rotary Club and Bi-Racial Committee.

"He is obligated to no one and has the outspoken courage of his convictions," Drs. Murray and Cook wrote. "All of us in Florida have the same respect for and confidence in him that his own group has."

Medicaid Peer Review Contract

The Florida Medical Foundation and the Florida Department of Health and Rehabilitative Services have agreed to a nine-month contract for peer medical utilization review (PMUR) under the Medicaid Program effective on October 31 after four years of negotiations. Its provisions are similar to those in a contract existing for several years between the Foundation, Blue Shield of Florida and H.E.W. in connection with the Medicare Program.

Under the agreement, the Foundation will evaluate cases referred to it by the Department for quality, appropriateness, necessity and cost of care.

The Department, among other things, will develop profiles of practice for each major specialty for use as a screening base to identify unusual patterns of practice.

The contract also provides for reimbursement of Foundation administrative expenses and professional review time.

Heart Association Announces Writing Awards Contest

The American Heart Association's Florida Affiliate has announced the Second Annual Steve Yates Medical Writing Awards Contest.

Purpose of the contest is "to honor individuals whose creative efforts in any local medium of mass communications are judged to have contributed most to public understanding of the heart and circulatory system, progress in research, and advances in the prevention, care and treatment of cardiovascular diseases."

Seven prizes of \$200 each will be available in daily and weekly newspaper, book, magazine, film, television and radio categories.

Entries published or presented anytime during 1977 will be eligible. The deadline for entries is March 1, 1978.

Information may be obtained by contacting: American Heart Association Florida Affiliate, P. O. Box 10100, St. Petersburg, FL 33733.



HILL CREST HOSPITAL — For Intensive Treatment of Psychiatric Disorders

This 113-bed non-governmental psychiatric hospital provides modern facilities for diagnosis and treatment of patients with all degrees of illness, including those who show severely disturbed behavior. Alcoholic and drug abuse patients are also accepted.

In addition to care by psychiatrists and by consultants in all medical specialties, the treatment program includes occupational, recreational, and physical therapy, social services, and tutoring. Emphasis is on short-term, intensive treatment of voluntary patients.

Hill Crest is a member of: American Hospital Association, National Association of Private Psychiatric Hospitals, Alabama Hospital Association, Birmingham Regional Hospital Council.

Accredited by Joint Commission on Accreditation of Hospitals. Medicare Approved. Blue Cross Participating Hospital.

HILL CREST HOSPITAL

HILL CREST FOUNDATION, INC.

6869 Fifth Avenue South

Birmingham, Alabama 35212

PHONE: (205) 836-7201



Ralph E. Johnson, M.D., . . . a national leader in the use of radiation for treatment of cancer, has joined the Division of Radiation Therapy at the University of Florida College of Medicine as Professor of Radiology.

Since 1966, Dr. Johnson has served as director of a branch of the National Cancer Institute dealing with radiation treatment of tumors. He is a 1958 graduate of Northwestern University Medical School.

An affiliation agreement . . . has been negotiated between the University of Miami School of Medicine and the National Parkinson Foundation.

The contract calls for a one-year study designed to foster a long term relationship devoted to research into prevention and treatment of Parkinsonism.

Under the agreement, Lee Alan Bricker, M.D., Associate Professor of Medicine at Miami, is named directing medical consultant to the Foundation. A Medical-Scientific Advisory Board will be chaired by Dr. Thomas Chase of the National Institutes of Health and will include University of Miami faculty.

Ira M. Feldman, M.D., of North Miami Beach . . . has been elected to Fellowship in the American College of Cardiology.

Yank D. Coble, Jr., M.D., of Jacksonville . . . has been elected President of the Florida Endocrine Society.

Dr. Coble is Vice President of the Duval County Medical Society and Chairman of the Council on Scientific Activities of the Florida Medical Association.

Roger T. Sherman, M.D., of Tampa . . . has been named President-Elect of the American Association for Surgery of Trauma.

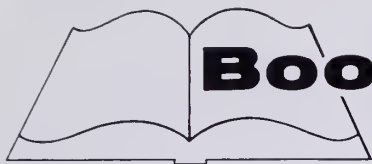
Dr. Sherman, Professor and Chairman of the Department of Surgery at the University of South Florida College of Medicine, was elected at the Association's annual meeting in September in Detroit.

Juan A. del Regato, M.D., of Tampa . . . has been awarded a Gold Medal for achievements in radiation therapy by the American Society of Therapeutic Radiologists.

Dr. del Regato, a professor at the University of South Florida College of Medicine, was a founder of the Society and served as its President in 1974-75. He is the first American radiotherapist to establish a training program for therapeutic radiologists, and is also the co-author of a standard textbook on diagnosis and treatment of cancer.

A native of Cuba, Dr. del Regato completed his medical education at the University of Paris, France, and was a Research Fellow at both the Curie Foundation of Paris and the National Cancer Institute in Bethesda, Md.

He is a member of the Hillsborough County Medical Association, the Florida Medical Association, and a number of other professional organizations.



Book Reviews

Book Review Editor — F. Norman Vickers, M.D.

Income Redistribution, edited by Colin D. Campbell. 267 Pages. Price \$4.75 (paperback), \$9.75 (cloth). American Enterprise Institute for Public Policy Research, Washington, D.C., 1977.

An introduction by the Editor outlines the subjects discussed at a conference on income redistribution held in Washington on May 20-21, 1976 which was sponsored by the Institute For Public Policy Research and the Hoover Institute On War, Revolution and Peace, two think tank institutes of scholars who consider governmental programs leading the country toward an egalitarian (equalitarian) society.

The scholars agree, in general, that the people want political and social equality and the poor taken care of, but that there is no real pressure for equality of income at the present. A discussion of the various programs reveals that Social Security Insurance is really a transfer system; Medicare and Medicaid have exploded health care costs; Unemployment Insurance may actually create unemployment; Social Security rather than supplementing inadequate savings may depress savings and induce retirement.

Discussion of our progressive income tax system designed after the great depression with redistribution in mind — the principal justification of progressivity — brought out that since then an array of welfare programs have brought about considerable redistribution of income, thus removing much of the justification for the progressive tax. Also discussion indicated that the massive growth in government spending (40% of G.N.P.) necessitates a shift from redistribution to revenue effects. It was pointed out that a degressive tax (uniform tax on all income above an exempt level) would reduce or eliminate much of the complexity which now typifies the progressive tax.

Much of this discussion might seem esoteric were it not for the observation that, "we do not know the extent to which problems of crime corruption, demoralization and anti-social behavior which beset our cities are due to highly visible and dramatic differences of opportunity and consumption. It would be impudent to ignore the possible connection and to rely on police and prisons to cope with the problem of anti-social behavior."

I highly recommend this enlightening discussion of welfare programs, social security and our progressive income tax.

Hoyt C. Taylor, M.D., F.A.C.S.
Port St. Lucie

Dr. Hoyt is in the private practice of Emergency Medicine and Obstetrics in Port St. Lucie.

Review of Physiological Chemistry, 16th Ed. by Harold A. Harper, Ph.D.; Victor W. Rodwell, Ph.D. and Peter A. Mayes, Ph.D., D.Sc. 681 Pages. Price \$13.00. Lange Medical Publications, Los Altos, Calif., 1977.

This soft-bound volume is a rather detailed review of current knowledge of physiologic chemical processes. Much of the volume will have little interest for the average practitioner, but several of the chapters, especially those dealing with gastrointestinal absorption and function, biliary function and the chemistry of respiration, are well done and provide excellent reviews of the basic physiologic processes involved in these body systems. The chapter dealing with the chemistry and function of the hormones is also well done. Lamentably, however, none of the chapters seem particularly oriented toward the clinical problems encountered in everyday practice. Overall, the organization of the book is somewhat confusing as the more clinically-oriented chapters are interspersed with those dealing with basic physiology. It would be far more helpful to have the book organized with the physiologic chapters as introduction followed by the chapters dealing with the organ systems as a whole. The text is well illustrated and contains up-to-date bibliographies at the conclusion of each chapter. This volume certainly provides an excellent review of physiologic chemistry, but will find limited usefulness in the library of the practicing physician. It should be well recommended to medical students and housestaff.

Bradley M. Rodgers, M.D.
Gainesville

Dr. Rodgers is a Pediatric Surgeon at the University of Florida College of Medicine.

Books Received

Receipt of the following books is acknowledged. Medical readers interested in reviewing particular books are invited to address requests to the Book Review Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.

Healthy Pregnancy — The Yoga Way by Judi Thompson (Foreword by James C. Baker, M.D.). 148 Pages. Illustrated. Price \$3.95. Doubleday & Company, Inc., Garden City, New York, 1977.

BT Behavior Therapy, Strategies for Solving Problems in Living by Spencer A. Rathus, Ph.D., and Jeffrey S. Nevid, Ph.D. 314 Pages. Illustrated. Price \$8.95. Doubleday & Company, Inc., Garden City, New York, 1977.

Labor & Delivery, An Observer's Diary by Constance A. Bean with an introduction by Gerald Cohen, M.D., 203 Pages. Price \$7.95. Doubleday & Company, Inc., Garden City, New York, 1977.

Controlled Substances Inventory List, by the United States Department of Justice, Drug Enforcement Administration, 293 Pages. Washington, D.C., 1977.

General Ophthalmology, 8th Edition, by Daniel Vaughan, M.D., and Taylor Asbury, M.D. 379 Pages. Illustrated. Price \$12.00. Lange Medical Publications, Los Altos, California, 1977.

The Nervous System by William F. Ganong, M.D., 226 Pages. Illustrated. Price \$8.00. Lange Medical Publications, Los Altos, California, 1977.

Blood Policy: Issues and Alternatives, edited by David B. Johnson. Page 212. Price \$4.75. American Enterprise Institute, Washington, D.C., 1977.

Handbook of Pediatrics by Henry K. Silver, M.D., C. Henry Kempe, M.D. and Henry B. Bruyn, M.D. 723 Pages. Price \$9.00. Lange Medical Publications, Los Altos, California, 1977.

Plagues and People by William N. McNeill. 340 Pages. Price \$3.50 (paperback). Anchor Press/Doubleday, Garden City, N.Y., 1977.

The Doctors and Patients Handbook of Medicines and Drugs by Peter Parish, M.D. 412 Pages. Price \$5.95. Alfred A. Knopf, New York, 1977.

Nothing to Fear, Coping With Phobias by Fraser Kent. 204 Pages. Price \$7.95. Doubleday & Company, Inc., Garden City, New York, 1977.

Modern Cardiology by John D. Cantwell, M.D. 468 Pages. Illustrated. Price \$24.95. Butterworths, Woburn, Massachusetts, 1977.

INFORMATION FOR AUTHORS

Manuscripts should be submitted to the Editor of the Journal, Florida Medical Association, P.O. Box 2411, Jacksonville, Florida 32203, in original and one duplicate copy. Copy should be typewritten and double spaced.

Author Responsibility. The author is responsible for all statements made in his work, including changes made by copy editor. Manuscripts are received with the understanding that they are not simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of the Journal and may not be published elsewhere without permission from the author and the Journal.

Each of the following should begin on a new page: synopsis-abstract, first page of text, legends for illustrations, tables and acknowledgments. Each page should include a running head and surname of senior author.

Synopsis-Abstract. All manuscripts should include a 150 word, maximum length, synopsis-abstract which is a factual (not descriptive) summary of the work. This replaces the summary and precedes your article.

Title should be short, specific, clear and amenable to indexing.

List affiliations for each author. If author's present affiliation is different from affiliation under which the work is done, both should be given.

References. The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to **Index Medicus**, volume number, page numbers and year of publication. All references must be cited in text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, we reserve the right to eliminate with notation: References are available from the author(s) upon request.

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. No changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

Illustrations. Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. The entire cost of reproducing color illustrations is the responsibility of the author(s). Omit all illustrations which fail to increase understanding of text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed, double-spaced on separate sheet of paper. The following information should be typed on an adhesive strip and affixed to back of illustration: figure number, title of manuscript, name of author and arrow indicating top. Tables should be self-explanatory and should supplement, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publications should be designated "For Publication."

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Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.

Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

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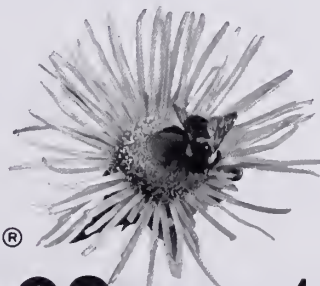
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Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted. Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

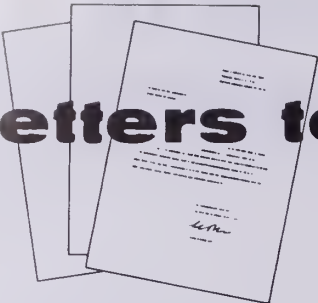
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Letters to the Editor

To the Editor: In reading of the death of Dr. Weech of Gainesville, I found it interesting that he gave the first injection of an antibiotic in the United States. My father, J. M. Rogers, M.D., was a pioneer in the use of prontosil in his practice on the foreign mission field in Korea in 1935 and 1936. I would assume that prontosil and prontosil would be the same or similar products. He got his shipped from Bayer in Germany via Trans-Siberian railway and his first patient had streptococcic meningitis. If my memory serves me correctly, it was a pink liquid solution and he was skeptically enthusiastic about its effect. The patient had four wives and the summer was hot, so they fanned him continuously both day and night. He appeared to be recovering from the meningitis, which was nearly miraculous, but developed pneumonia and died. Dad felt strongly that his wives contributed to his demise by their extensive fanning and attention.

I've been on the lookout for articles in our Journal about the use of aloe vera extract for medicinal purposes. Since coming to South Florida in 1953, I've had occasion to hear of the use of this home remedy for sunburn, treatment of burns and superficial wounds, taken internally for peptic ulcers and for lowering of cholesterol. One patient warned me to be certain not to use it indiscriminately in the oral route with a patient taking insulin for juvenile diabetes. Seems that it might cause a hypoglycemic episode. Let's hear from the country doctors about this.

David R. Rogers, M.D.
Tavernier

The young want to change the world
The old want to change the young.

Dear Mr. Thrasher: Thank you very much for your excellent remarks on the Right to Medical Care in the current FMA Journal. This parallels very much a somewhat more lengthy article of several years ago in the New England Journal of Medicine which you might be interested in referring to and the reference for which, unfortunately, I presently lack. This same article dealt with the right to medical care, and it further pointed out that logically the only way that this right can exist is by enslavement of the Medical Community. Thus the public cannot have a right to this care without interfering with the Rights of Freedom of those who must supply the care. It certainly is a clear cut issue or was until we became so intoxicated with "Rights."

Thank you very much for your remarks and we appreciate all that you are doing for our community.

Joel Mattison, M.D.
Tampa

Mr. Thrasher is FMA Legal Counsel.

Journal Subscriptions Go Up On January 1

The cost of single issues and subscriptions to *The Journal* will increase on January 1.

One-year subscriptions will increase from \$10 to \$12. Two and three-year subscriptions are available at \$22 and \$33.

Single copies will cost \$1.50, except for special issues, which are priced at \$2.50. All orders originating in Florida are subject to 4% tax.

MEETINGS

Approved by FMA Committee on Continuing Medical Education

1978

JANUARY

Fifth Annual Symposium In Pediatric Nephrology: Current Concepts In Diagnosis and Management, Jan. 4-7, Miami.*

Management for the Physician and Dentist, Jan. 5, Americana Hotel, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

Fifteenth Annual Seminar In Anesthesiology, Jan. 5-8, Americana Hotel, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

Cardiac Arrhythmias, Jan. 6-8, Omni International Hotel, Miami. For information: Ralph Lassara, M.D., Veterans Administration Hospital, 1201 N.W. 16th Street, Miami 33125.

Post Convention Seminar In Anesthesiology, Jan. 8-13, Sam Lord's Castle, Barbados, B.W.I. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

Miami Winter Symposia, Jan. 9-12, Miami.*

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Jan. 9-14, Miami.*

Seminar on Child Abuse for Physicians by Ruth Kempke, M.D. and Henry Kempe, M.D., Jan. 12, Gainesville. For information: Candy Tolbert, Department of Pediatrics, University of Florida College of Medicine, Gainesville (904) 392-3331.

Diagnostic Radiology for Primary Care and Emergency Physicians, Jan. 12-15, Key Biscayne. For information: Caral L. Sparks, 3900 N. W. 79th Street, Miami.

Seminar on Child Abuse for Other Health Professionals by Ruth Kempke, M.D. and Henry Kempke, M.D., Jan. 13, Gainesville. For information: Candy Tolbert, Department of Pediatrics, University of Florida College of Medicine, Gainesville (904) 392-3331.

A Symposium on Depression, Jan. 13-15, Don CeSar Resort Hotel, St. Petersburg Beach+

Third Annual Seminar, "Problems in Pediatric Radiology," Jan. 13-17, Sonesta Beach Hotel and Tennis Club, Key Biscayne.*

Symposium on Large Bowel Cancer: Early Diagnosis and Screening Programs, Jan. 14, Sarasota Hyatt House, Sarasota. For information: Richard J. Field, 1901 Arlington St., Sarasota 33579.

Postconvention Seminar In Pediatric Radiology "Radiographic-Pathologic Correlation of Pediatric Diseases," Jan. 17-20, The Colony Beach and Tennis Resort, Sarasota.*

Art and Science in the Therapy of Difficult Problems in Surgery, Jan. 18-21, Miami.*

10th Annual Postgraduate Seminar In Pediatric & Adult Urology, Jan. 19-21, Carillon Hotel, Miami Beach. For information: Victor Politano, M.D., 3900 Northwest 79th Ave., Suite 469, Miami 33166.

Advances In Endocrinology '78, Jan. 20-21, Hyatt House, Kissimmee. For information: Samuel E. Crockett, M.D. or Barry E. Seiger, M.D., 1416 S. Orange Avenue, Orlando 32806.

Corneal and Plastic Ophthalmic Surgery and Diseases of the Eye, Jan. 22-27, Miami.*

3rd Annual Review and Recent Practical Advances in Pathology, Jan. 22-27, Miami.*

A Neurological Update: 1978, Jan. 23-27, Miami.*

3rd International Symposium on Stress, Jan. 26-27, Gainesville Hilton, Gainesville.**

Lung Cancer Update 1978 — Diagnosis, Staging and Treatment, Jan. 26-27, Medical Center Auditorium, Tampa. For information: David A. Solomon, M.D., 13000 N. 30th Street, Tampa 33612.

Emergency Cardiac Care, 1978, Jan. 26-29, Americana Hotel, Miami Beach. For information: Caral L. Sparks, 3900 N. W. 79th St., Miami 33166.

Cancer Chemotherapy, Jan. 27, Veterans Administration Center, Bay Pines. For information: John C. Gallagher, M.D., Veterans Administration Center, Bay Pines 33504.

Coronary Disease, Exercise, Testing and Cardiac Rehabilitation, Jan. 27-29, Orlando Hyatt House, Orlando. For information: William E. James, Ph.D., One Inverness Dr., Englewood, Colorado 80110.

Thirteenth Annual Scientific Assembly of the American Society of Contemporary Medicine and Surgery, Jan. 30 - Feb. 3, Americana Hotel, Miami Beach. For information: John G. Bellows, M.D., 6 North Michigan Avenue, Chicago 60602.

*For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152, Tel. (305) 547-6716.

**For Information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143.

+For Information: Contact Theron A. Ebel, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2074.

FEBRUARY

Hematopathology, Feb. 1-3, Tampa+

Twelfth Annual Symposium on Cosmetic Surgery, Feb. 2-4, Cedars of Lebanon Hospital, Miami. For information: Thelma MacGregor, Seminar Sec., Cosmetic Surgery Symposium, Cedars of Lebanon Hospital, 1400 N.W. 12th Avenue, Miami 33136.

Florida Cleft Palate Association Annual Meeting, Feb. 3-4, Konover Hotel, Miami beach. For information: William Silver, M.D., 6950 North Kendall Drive, Miami 33156.

23rd Central Florida Medical Meeting, Feb. 3-5, Contemporary Resort Hotel, Orlando. For information: Edward Ackerman, M.D., 800 West Morse Blvd., Winter Park 32789.

Management of Cardiac Disease — 1978, Feb. 3-5, Omni International Center, Miami. For information: Robert J. Myerburg, M.D., and Agustin Castellanos, Jr., M.D., Division of Cardiology, University of Miami, P.O. Box 520875, Miami 33152.

South Florida Psychiatric Society Annual Symposium, Feb. 4, Dupont Plaza Center, Miami. For information: Doris Shellow, P.O. Box 331266, Miami 33133.

Fourth Annual Vail Conference in Anesthesiology, Feb. 4-11, Miami.*

OB-GYN Caribbean Seminar, Feb. 4-11, Miami.*

Thirteenth Annual Postgraduate Course — Internal Medicine 1978, Feb. 5-10, Sheraton Four Ambassadors Hotel, Miami. For information: J. Bocles, M.D., University of Miami School of Medicine, Department of Internal Medicine, P.O. Box 520875, Miami 33152.

Clinical Nephrology and Hypertension, Feb. 6-8, Doral Beach Hotel, Miami. For information: Office of CME Mount Sinai Medical Center, 4300 Alton Road, Miami beach 33140.

Florida Midwinter Seminar in Ophthalmology, Feb. 6-8, Miami.*

13th Annual "Internal Medicine 1978," Feb. 6-11, Miami.*

Florida Midwinter Seminar in Otolaryngology, Feb. 9-11, Miami.*

Internal Medicine Update '78, Feb. 13-18, Dutch Inn, Lake Buena Vista. For information: Barry E. Sieger, M.D. or Samuel E. Crockett, M.D. or Roy Behnke, M.D., 1416 S. Orange Avenue, Orlando 32806.

Basic Clinical Electrocardiography and Arrhythmia Management, Feb. 17-19, Bahia Mar, Fort Lauderdale. For information: William E. James, Ph.D., One Inverness Drive, Englewood, Colorado 80110.

Pediatric Dermatology Seminar, Feb. 23-26, Konover Hotel, Miami Beach. Program to be followed by a one week post seminar flight and cruise to the Caribbean and South America. For information: Guinter Kahn, M.D., 16800 N.W. 2 Ave., Suite 401, N. Miami Beach 33169.

Basic Neurology for Psychiatrists, Family Practitioners and General Practitioners, Feb. 26-Mar. 3, Miami.*

MARCH

Hepatobiliary Disease in Clinical Practice, Mar. 2-4, Miami.*

5th Annual Selected Topics in Urology, Mar. 2-4, Gainesville Hilton, Gainesville.**

First International Congress on Colonoscopy and Disease of the Large Bowel, Mar. 2-4, Fontainebleau Hotel, Miami Beach. For information: John P. Christie, M.D., 7400 N. Kendall Drive, Suite 311, S. Miami 33156.

Perinatology II High Risk Pregnancy Conditions and Their Management, Mar. 2-4, Hyatt House, Orlando. For information: Amelia C. Cruz, M.D., University of Florida College of Medicine, Department of Obstetrics and Gynecology, Box J-294, JHMC, Gainesville 32610.

Problems in Rheumatology, Mar. 2-5, Don CeSar Beach Resort Hotel, St. Petersburg Beach. For information: Bernard F. Germain, M.D., University of South Florida, Tampa 33620.

Management of Diabetes Mellitus, Mar. 3, Veterans Administration Center, Bay Pines. For information: John C. Gallagher, M.D., Veterans Administration Center, Bay Pines 33504.

3rd Annual Conference in Skin Disorders for Nurses, Mar. 3-5, Miami.*

Postgraduate Seminar in Dermatology, Mar. 3-5, Miami.*

Eighth Annual Radiological Special Procedures Seminar, Mar. 4-7, Konover Hotel, Miami Beach. For information: Mrs. Lucy Kelley, 6752 S.W. 34th Court, Miramar 33023.

Gateway Cancer Symposium, Mar. 6-8, Orlando Hyatt House, Kissimmee. For information: Charles Taylor, 1001 S. MacDill, Tampa 33609.

16th Annual Clinical Radiology Seminar "Controversies in Radiology," Mar. 7-11, Konover Hotel, Miami Beach. For information: Mrs. Lucy Kelley, 6752 S.W. 34th Court, Miramar 33023.

Symposium on Ocular Trauma, Mar. 11, Tampa+

2nd Annual Seminar "Practical Aspects of Computed Tomography", Mar. 12-15, Konover Hotel, Miami Beach.*

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Mar. 13-18, Miami.*

Practical Aspects of Ultrasonography, Mar. 15-18, Konover Hotel, Miami Beach.*

Infectious Disease and Immunology, Mar. 17-18, Dutch Inn, Lake Buena Vista. For information: Barry E. Sieger, M.D. or Samuel E. Crockett, M.D., 1416 South Orange Avenue, Orlando 32806.

Current Clinical Concepts in Otolaryngology, 1978, Mar. 22-24, Miami.*

Tenth Teaching Conference in Clinical Cardiology, Mar. 22-25, Americana Hotel, Miami Beach. For information: Michael S. Gordon, M.D., Ph.D., University of Miami School of Medicine, Division of Cardiology, P.O. Box 520875, Biscayne Annex, Miami 33152.

9th Annual Topics in Internal Medicine, Mar. 23-25, Gainesville Hilton, Gainesville.**

Seminar for Chronic Pain, Mar. 31 - Apr. 2, Americana Hotel, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

APRIL

Malignant Hyperthermia, Apr. 6-9, Miami.*

Tutorial Courses of Instruction in Coronary Care for the Practicing Physician, Apr. 10-15, Miami.*

Obstetric Anesthesia — Fourth Annual Seminar in Memory of Virginia Apgar, M.D., Apr. 14-16, Americana Hotel, Miami Beach. For information: Frank Moya, M.D., 4300 Alton Road, Miami Beach 33140.

Sixth Annual Intensive Care Symposium, Apr. 15-17, Miami.*

Emergencies in Internal Medicine, Apr. 17-20, Miami.*

Advanced Electrocardiography and Arrhythmia Management for the Family Practitioner, Apr. 20-22, Gainesville Hilton, Gainesville.**

MAY

Second Annual Symposium on Underwater Medicine, May 4-8, Miami.*

Seizure Disorders, May 5, VA Center, Bay Pines. For information: John C. Gallagher, M.D., Chairman, Education Committee, VA Center, Bay Pines 33504.

Post-Convention Seminar and Diving Program, May 8-11, Miami.*

Pars Plana Vitreous Surgery - The Miami Technique, May 11-13, Miami.*

Family Medicine Update — 1978, May 18-21, Miami.*

7th Family Practice Review, May 22-26, Gainesville Hilton, Gainesville.**

JUNE

Review Course for Certification in Internal Medicine, June, Miami.*

Bascom Palmer Eye Institute Alumni Meeting and Seminar, June 9-11, Miami.*

Coronary Disease, Exercise Testing and Cardiac Rehabilitation, June 23-25, Orlando Hyatt House, Orlando. For information: William E. James, Ph.D., One Inverness Drive, Englewood, Colorado 80110.



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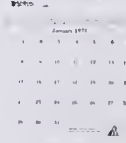
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Classified Ads

Physicians Wanted

FAMILY PRACTITIONERS

FAMILY PRACTICE—Excellent opportunity for physician to perform general practice in expanding North Florida community. Attractive 128-bed new hospital that provides excellent facilities for treatment. For additional information contact John E. Knight, Administrator, Lake Shore Hospital, Lake City, Florida 32055. Phone: (904) 752-2560.

FAMILY PRACTICE ASSOCIATE WANTED. Possibility of partnership in future. Contact: Ronald M. Thompson, M.D., 6215 South Dixie Highway, West Palm Beach, Florida 33405. Phone: (305) 582-7451.

GENERAL PRACTITIONER: For well equipped medical clinic immediately adjacent to 120 bed skilled nursing facility; would also act as medical director for nursing home. Salary 100% of intake. Contact: Administrator, Wakulla Manor Nursing Home, P.O. Box 508, Crawfordville, Florida 32327. Phone: (904) 926-7181.

FAMILY PRACTITIONER NEEDED for private practice in growing central Florida community. Hospital has just added new wing and expanded lab and radiology outpatient facilities. Easy access to Tampa, Orlando, Gulf Coast Beaches, 20 miles from Disney World and Sea World. Office space available and assistance. For further information contact Administrator, M. S. Jones, Morrow Memorial Hospital, Auburndale, Florida 33823. Phone: (813) 967-4148.

SPECIALISTS

WANTED — MEDICAL OPHTHALMOLOGIST, primarily for routine exams including refractions. Can be part or full time. Central Florida area. Write C-847, P.O. Box 2411, Jacksonville, Florida 32203.

URGENTLY NEEDED NEUROLOGIST FOR A LARGE MEDICAL COMMUNITY. Opportunity either solo or a joint-existing group. Please send curriculum vitae to C-832, P.O. Box 2411, Jacksonville, Florida 32203.

GENERAL SURGEON, SURGICAL SUBSPECIALISTS, RADIOLOGISTS, ORTHOPEDISTS, GYNECOLOGIST, OPHTHALMOLOGIST, OTOLARYNGOLOGIST WANTED to occupy building with busy five man internal medical group. New office building, centrally located in beautiful Delray Beach, Florida. Telephone: Ask for Mrs. Hanshumaker, (305) 278-3323 or write Drs. Debout, Wachtel and Pace, 117 N.E. 8th Street, Delray Beach, Florida 33444.

URGENTLY NEEDED NEUROSURGEON FOR A LARGE MEDICAL COMMUNITY. Opportunity either solo or a joint-existing group. Please send curriculum vitae to C-832, P.O. Box 2411, Jacksonville, Florida 32203.

CARDIOLOGIST, FAMILY PRACTITIONER. Immediate openings. Private solo practices, except FP could be partnership. Financial assistance including first year free rent in professional

building adjacent to hospital. Contact Claude Weeks, Executive Director, Flagler Hospital, P.O. Box 100, St. Augustine, Florida 32084. (904) 824-8411.

SEMI-RETIRED CERTIFIED INTERNIST SEEKING WELL QUALIFIED INTERNIST to share fully equipped office in Palm Beach, Florida. All services furnished. No investment required. Send curriculum vitae to C-842, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST: Board certified, with or without specialty, in a five doctor group, with a good opportunity for private practice in a growing area on the west coast of Florida. Write or call Dr. Bernhard J. Weinberg, 241 Nokomis Ave., Venice, Florida 33595. Phone (813) 484-2484 (weekdays) or (813) 485-8856 (evenings).

MISCELLANEOUS

LAMINAR FLOW OPERATING ROOMS tested for conformation to Federal Standard 209-B, also yearly recertification test performed. Contact Jake Truslow Company, P.O. Box E-S, Venice, Florida 33595. Phone: (813) 485-4617.

PSYCHIATRIST/G.P. PHYSICIAN — Openings are anticipated from time to time in well established Community Mental Health Center. Florida license required. This is a CMHC with four large programs: Drug Abuse Alcohol Counseling Center, Child Development Center and General Mental Health Program. Pensacola offers beautiful beaches and excellent recreational opportunities. No state income tax. Letters of inquiry, with resume, should be forwarded to Morris L. Eaddy, Ph.D., Executive Director, Community Mental Health Center of Escambia County, Inc., 1201 West Hernandez Street, Pensacola, Florida 32501. An equal opportunity employer.

UNIVERSITY PHYSICIAN FOR URBAN UNIVERSITY with Medical/Nursing Schools, and excellent fringe benefits. Contact L. E. Stevens, M.D., Director, University of South Florida, Student Health Services, Tampa, Florida 33620. An Equal Opportunity Employer.

PART TIME PHYSICIANS SPECIALIZING IN ORTHOPEDICS, GYNECOLOGY, PULMONARY DISEASE, PLASTIC SURGERY AND VASCULAR-CHEST SURGERY NEEDED by multispecialty 20 man group in North Miami Beach. Please visit our medical center and send curriculum vitae to The Aventura Medical Center, 2956 Aventura Boulevard, North Miami Beach, Florida 33180.

Situations Wanted

ORTHOPEDIC SURGEON, 30, married, university trained, available July 1978. Experienced in total joint replacement, desires partnership, group, or solo on Florida coast. American, Bilingual, Spanish-English. Write C-794, P.O. Box 2411, Jacksonville, Florida 32203.

PATHOLOGIST-CERTIFIED CP/AP, 47, Florida licensed, native U.S., excellent C.V. and experience as director. Current

post-grad. training and certification through 1980. Write: P.O. Box 11158, U.S. Post Office, 227 E. Ontario St., Chicago, Illinois 60611.

30 YEAR OLD FMG WITH FLEX—ECFMG and Florida license, board eligible, general surgery. Presently doing one year of peripheral vascular surgery. Desires solo, partnership or group. Will consider all locations in Florida. Contact: Antonio Vasquez, M.D., 2799 W. Grand Blvd., Detroit, Michigan 48202.

CARDIO-THORACIC SURGEON, University trained, open-heart, coronary by-pass and valvular surgery. Florida licensed. Seeks position with established group. Write C-785, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST-ENDOCRINOLOGIST, 30, ABIM certified, university trained. Seeks partnership or group practice in Southeast Florida beginning 7/78. Write C-830, P.O. Box 2411, Jacksonville, Florida 32203.

PEDIATRICIAN: 37 years old; Florida license, board eligible; neonatology subspecialty. Seeks partnership, group or hospital based practice. Desires relocation. Available January 1978. Contact: E. P. Nelson, M.D., 903 Hensley Heights, Man, West Virginia 25635.

ALLERGIST, board certified, A.B.A.I., desires solo, group or partnership. Available January 1978. Write C-833, P.O. Box 2411, Jacksonville, Florida 32203.

THORACIC CARDIOVASCULAR GENERAL SURGEON, now Clinical Professor of Surgery, wishes to transfer practice to Florida. Association or group desired. Hospital full time also considered. Write C-835, P.O. Box 2411, Jacksonville, Florida 32203.

PHYSICIAN, 26 years old, Florida licensed, board certified in pediatrics, with good mastering of English and Spanish, seeks relocation around Ft. Lauderdale area for any type of position part-time or full-time in pediatrics or emergency medicine. Contact: E. Jones, 5350 Arlington Expressway, Apt. 3809, Jacksonville, Florida 32211.

GENERAL AND VASCULAR SURGEON, 35, university trained, board certified, Florida licensed. Seeks practice opportunity, solo, partnership or group. Available 3 months notice. Write C-837, P.O. Box 2411, Jacksonville, Florida 32203.

BOARD CERTIFIED INTERNIST WITH GASTROENTEROLOGY subspecialty, age 39, seeks to purchase practice or to relocate with group/partnership, possess Florida license. Write C-839, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST/PULMONARY, 33, board qualified, university trained. Private practice experience. Will do internal medicine and pulmonary medicine. Available January 78. Reply to Charles Zavala, M.D., 2728 Oak Road #138, Walnut Creek, California 94596.

POSITION WANTED: 47, board eligible, wide experience, 8 years in anesthesia. 3 years in England. D.A. (Royal College). Licensed in Florida, available July 1977. Group or fee-for-service. Write C-796, P.O. Box 2411, Jacksonville, Florida 32203.

39 YEAR OLD INTERNIST IN PRACTICE in New Jersey for six years would like to relocate in South Florida. Looking for physician planning to retire. Call: (305) 261-0268.

PHYSICIAN AVAILABLE—30 years old, FMG with permanent visa. Florida licensed. Seeking career ER position. Three and one half years of surgical residency. Fluent English and conversational Spanish. Available immediately. Resume available upon request. Write C-846, P.O. Box 2411, Jacksonville, Florida 32203.

CARDIOLOGIST, 30, A.B.I.M., cardiology board eligible, extensive clinical, cath and echo experience. Desires association with cardiology or I.M. group. Available 6/78. Write J. Nelson, M.D., 105 Huntington Avenue, Danville, Pennsylvania 17821.

INTERNIST—University trained, board eligible, seeks association, partnership or group practice of general internal medicine on Florida Gulf Coast. Available July 1978. Write C-840, P.O. Box 2411, Jacksonville, Florida 32203.

ORTHOPEDIC SURGEON—29, board eligible on completion of training 7/78. Solo, group, partnership, multispecialty considered. Curriculum vitae on request. Box 42, Charlotte Memorial Hospital, Charlotte, N.C. 28203.

PHYSIATRIST, PHYSICAL MEDICINE AND REHABILITATION. I am looking to relocate in Florida, preferably combination of hospital and private practice. Medical degree from McGill; PM & R training at Albert Einstein Bronx, N.Y., fellow in PM & R in Canada, American board certified and licensed in Florida. Contact: S. H. Schacter, M.D., 267 Sheraton Drive, Montreal West, Quebec, Canada H4X 1N8.

39 YEAR OLD BOARD ELIGIBLE INTERNIST WITH SUBSPECIALTY TRAINING IN GASTROENTEROLOGY. F.M.G. trained at Case Western Reserve University. Actively practicing in small Florida town for the last four years. Wishes to relocate his practice in Jacksonville area. Would consider primary care. Write C-841, P.O. Box 2411, Jacksonville, Florida 32203.

POSITION WANTED: 35 years old, board certified general surgeon, wishes to relocate in Florida. Group, hospital based or partnership. Contact: Jorge A. Melendez, M.D., F.A.C.S., One Hillside Drive, Batavia, N.Y. 14020. Phone: (716) 343-5563.

INSURANCE COMPANY UNDERWRITING, OCCUPATIONAL MEDICINE, public health, or student health position desired by forty-one year old F.P. specialist with clinical and recent insurance experience. Please send full details of position in reply to C-809, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST-PULMONARY DISEASES, University trained FLEX N.Y., N.J., seeks group, solo or hospital based practice. Interested in primary care, willing to take over retiring doctor's practice. Prefer coastal area. Two years E.R. experience. Available July 1978. Reply Ruston F. Damania, M.D., 108 Oak St., Ridgewood, N. J. 07450. Phone (201) 444-0487.

BOARDED FAMILY PRACTITIONER will work with busy General Practitioner or Internist. Terms open for discussion. Write C-844, P.O. Box 2411, Jacksonville, Florida 32203.

RHEUMATOLOGIST-INTERNIST, 31, married, university trained, Florida license, Spanish knowledge, seeks practice in

group, hospital, full time, solo, teaching welcome. Curriculum vitae on request. Available July 1978. Write C-843, P.O. Box 2411, Jacksonville, Florida 32203.

DIABETOLOGIST - ENDOCRINOLOGIST - INTERNIST, A.B.I.M., certified, Endocrine board eligible. Desires private practice, solo or partnership. Has board clinical and lab experience. Will do part general internal medicine. Available July 1978. Write C-845, P.O. Box 2411, Jacksonville, Florida 32203.

POSITION WANTED IN FAMILY PRACTICE: E.C.F.M.G. and FLEX passed. Completing F.P. residency. Will consider solo, group or emergency room. Madhur, M.D., 31 Minebrook Road #177A, Edison, New Jersey 08817. Phone (201) 494-5755.

Practices Available

GENERAL PRACTICE FOR SALE: Located in fast growing area in Tampa. Fully equipped. Will introduce. Reason for leaving: going into residency training. For further information write to: John A. Johnson, M.D., 13857 Oak Forest Blvd., North, Seminole, Florida 33542. Phone: (813) 393-9367 (nights).

Equipment

NEW AUTOMOBILES. Save up to \$1,000 on all U.S. makes. Statewide delivery with full warranty. For quote send itemized needs to Aristocrat Auto Brokers, 11125, S.W. 74th Ave., Miami 33156.

PHYSICAL THERAPY EQUIPMENT FOR SALE: One Stainless Steel Whirlpool with agitator, Oblong-approx. size 18" x 36" x 28" deep; one Stainless Steel Whirlpool with agitator, Oblong - approx. size 16" x 28" x 18" deep; one intermittent Cervical Traction Apparatus Chair - mfg'd by Tractolator Co.; one Preston shoulder exercise wheel — 36" diameter; one MW 200 Burdick Microwave Diathermy — Serial #6248; one MW 200 Burdick Microwave Diathermy — Serial #2811; one MW-300 Mettler Auto-Therm Diathermy Unit Serial #111H1531; One MW-300 Mettler Auto-Therm Diathermy Unit Serial #101H1503; one Ut-400 Burdick Ultrasound SN 5345; one Burdick Muscle Stimulator SN MS-600; one Burdick Diathermy SN 7929-MF-49. Contact Alex Trombly (813) 253-2667, 8:00 - 5:00.

Real Estate

FOR SALE: Prestige home on St. Johns River, Jacksonville, near Timuquana Country Club. Designed by Miami architect, Gordon Severud, AIA. Beautifully landscaped lot 109 x 500, inside swimming pool, four bedrooms, paneled den, fireplace, separate guest area. Write C-817, P.O. Box 2411, Jacksonville 32203. For appointment call (904) 354-5554, weekdays 9:00-4:30.

OUTSTANDING LOCATION FOR SPECIALIST: St. Nicholas Medical Center. Central location, off street parking and all utilities furnished (including janitor service). Contact W. G. Allen, Jr., Owner-Manager, St. Nicholas Medical Center, 3127 Atlantic Boulevard, Jacksonville 32207. Phone: (904) 398-5500.

LAKELAND, FLORIDA: FOR SALE, 6% down. Air-conditioned office for one to three physicians. Main Street, 168 x 140 ft.; double parking lots; extra cottage. Dr. L. Polskin, Box 15966, Honolulu, Hawaii 96815.

DESIRABLE SPACE AVAILABLE. Ample free parking, janitor service, A/C, 440 sq. ft., reception room, secretary and doctor's office, small examining room with water. 1333 S. Miami Avenue, Miami 33130. Reasonable terms. Manager on premises, Rm. 111. Phone: (305) 374-8210.

ST. PETERSBURG, FLORIDA: For rent, furnished, well designed office with front parking. Adjoins pharmacy. Centrally located. G.E. x-ray, Lanier Tel-Edisette Dictation system, office furnishings, desk, cabinets, IBM typewriter, etc. Essentially fully equipped. Minimal start-up cost. R. E. Peterson, M.D., 49th-8th St. North, Naples, Florida 33940. Phone: (813) 262-1119.

JACKSONVILLE, FLORIDA FOR LEASE: New medical office, approximately 1,300 sq. ft. Interior can be designed to tenant's specifications. Convenient to Memorial and Baptist Hospitals. Located in University Professional Center. Phone: (904) 731-1008.

TAMPA: FOR RENT OR LEASE, medical center adjacent St. Joseph Hospital, 3 treatment rooms, share waiting room, unlimited parking, 4600 N. Habana, Suite 33, Tampa, Florida 33614.

WEST PALM BEACH: New one story purely medical building offices for rent. Ready to occupy suites. Central location. Four minutes to I-95. Reasonable. Call (305) 655-8620 — evenings (305) 833-2952.

DOCTOR'S BUILDING, land (50 x 135), private parking. One block general hospital. Present office 900 sq. ft., can expand to 1,700 sq. ft., zoned. Family practice available, will introduce. James G. Makol, M.D., 46 N.W. 168 St., N. Miami Beach 33169. Phone: (305) 651-4520. Before noon: (305) 932-5186.

DELRAY BEACH—Single story medical complex near I-95 and western suburbs. Easily accessible on main roads but in primarily residential atmosphere. Medical lab and pharmacy in complex plus two family practices in addition to specialties. Reasonable rental rates plus allowance for leasehold improvements. Contact Gringle and Doherty, Inc. REALTORS, Management Agents, P.O. Box 686, Delray Beach, FL 33444. Phone: (305) 278-2628.

NICE OFFICE SPACE AVAILABLE: Two examining rooms (with a third furnished one available in afternoon). Large, attractive, furnished, waiting area. Convenient Riverside location. Reasonable rent. 1,200 sq. ft. 1503 Oak Street, Jacksonville. Phone: (904) 353-7416.

Classified advertising rates are \$7.50 for the first 25 words or less and 25 cents for each additional word. Deadline is first of month preceding month of publication.

The Florida Medical Association offers placement assistance through the Physician Placement Service, P.O. Box 2411, Jacksonville, Florida 32203. This service is for the use of physicians seeking locations, as well as physicians seeking associates, and is without charge.

PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy—and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information

is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA

THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST., N. W., WASHINGTON, D. C. 20005

Florida Organizations of Medical Interest

Meetings and Officers

Organization	President	Secretary	Annual Meeting
Florida Medical Association	Louis C. Murray, Orlando	Robert E. Windom, Sarasota	Hollywood-by-the-Sea, May 3-7, 1978
Florida Specialty Societies			
Allergy Society	Rodger J. Zwemer, Vero Beach	Robert H. Cohan, Pensacola	
Anesthesiologists, Society of	John Kruse, Jacksonville	John L. Weare, Melbourne	
Chest Phys., Fla. Chap., Am. Col.	Adil Sokmensuer, W. Palm Beach	Marcos Barrocas, Key Biscayne	
Colon & Rectal Surgeons, Soc. of	Walter Hamilton, St. Petersburg	Shed Roberson, Daytona Beach	
Dermatology, Society of	Louis Simonson, Hollywood	Dale R. Charneco, Jacksonville	
Emergency Phys., Fla. Chap.	Julius M. Garner, Orlando		
Endocrine Society	Yank D. Coble Jr., Jacksonville	Henry J. Baskin, Orlando	
Family Physicians, Acad. of	Dick L. Van Eldik, Lake Worth	Charles A. Dunn, Miami	
Gastroenterologic Society	Joel Fyvolent, Tampa	Pedro J. Greer, Miami	
Internal Medicine, Society of	Rose London, Miami Beach	Charles Hayes, Jacksonville	
Neonatal-Perinatologists, Soc. of	Donald Eitzman, Gainesville	Gregor Alexander, Orlando	
Nephrology, Society of	Dana L. Shires, Tampa	James L. Katsikas, Miami	
Neurology, Society of	Allan Herskowitz, Miami	Beauregard L. Bercaw, Clearwater	
Neurosurgical Society	Hubert A. Aronson, Miami	Frank Davis, Tallahassee	
Nuclear Physicians, Assn. of	Dorothy Lloyd, Orlando	Herman E. Rolfs, Ft. Lauderdale	
Obstetric & Gynecologic Society	John E. Startzman, Orlando	Taylor H. Kirby, Gainesville	
Oncologists, Clin., Fla. Soc.	Robert C. Seelman, Melbourne	Jack W. MacDonald, Tallahassee	
Ophthalmology, Society of	Raymond J. Sever, Temple Terrace	Reginald J. Stambaugh, W.P.B.	
Orthopedic Society	Ronald Mann, III, Miami	Howard P. Hogshead, Jacksonville	
Otolaryngology, Society of	T. Wallace Hahn, Pompano Beach	John A. Coleman, Winter Park	
Pathologists, Society of	Thomas P. Wood, Tallahassee	Daniel Seckinger, Miami	
Pediatric Cardiologists, Assn. of	Henry Gelband, Miami	Robert H. Miller, Jacksonville	
Pediatric Surgeons, Assn. of	James L. Talbert, Gainesville	Ralph Swank, II, Tampa	
Pediatric Society, Fla. Chap. Am. Acad. of Pediatrics	Andrew W. Townes, Orlando	Thomas H. Greiwe, Tampa	
Physical Medicine & Rehab., Soc. of	David L. Lipkin, N. Miami Bch.	Hector A. Freytes, Miami	
Physicians, Am. Col.	Charles K. Donegan, St. Petersburg		
Plastic & Recon. Surgery, Soc. of	Alan S. Rapperport, Miami	Jack D. Norman, Miami	
Preventive Medicine, Soc. of	James T. Howell, W. Palm Beach	John F. McGarry, Orlando	
Psychiatric Association	McKinley Cheshire, W. Palm Bch.		
Radiological Society	Alfred Schick, Clearwater	Sylvan H. Sarasohn, N. Miami	
Rheumatology, Society of	Roy Altman, Miami	W. J. Blechman, N. Miami Beach	
Surgeons, Fla. Chap., Am. Col.	John Fletcher, Tampa	Arthur Waltzer, Tampa	
Surgeons, General, Assn. of	Samuel M. Day, Jacksonville	Robert H. Hux, Leesburg	
Surgeons, Sur. Div., Intl. Col.	Julian A. Rickles, Miami Beach	Michael Butler, Orlando	
Surgeons, Thoracic Society	Robert Trumbo, Orlando	Perry B. Larsen, Miami	
Thoracic Society	Gerald N. Olsen, Jacksonville	Wilbur G. Avery, Miami	
Urological Society	Alvie C. McCully, Tallahassee	H. A. P. Leininger, Coral Gables	
FLORIDA DIVISION:			
American Cancer Soc., Inc.	Robert A. Mills, Jacksonville	Barbara Weintraub, Miami	Palm Beach, Sept. 29-Oct. 1, 1978
American Heart Assn., Fla. Aff.	James L. Mason, St. Petersburg	Mrs. William H. Elarbee, Vero Beach	St. Petersburg, June 4, 1978
Arthritis Foundation, Fla. Chap.	Earl Treadway, Tallahassee	Christia Scarbrough, Sarasota	Orlando, May 1978
Crippled Children & Adults, Easter Seal Society, Inc.	John A. Nelson, St. P'burg	Katherine Eiland, Miami	Orlando, January 29, 1978
Epilepsy Foundation, Inc.	Mark Buchbinner, Miami	Carol Otts, Pensacola	Tampa, January 14, 1978
Kidney Foundation, National	Jay M. Whitworth, Jacksonville		Jacksonville, April 15, 1978
Leukemia Society of America	Irving J. Whitman, Miami	Robert H. Newman, Miami	(Date unknown)
Lung Association	William E. Culbreath Jr., St. Petersburg	Earl L. Crona, Pensacola	April 14-15, 1978
March of Dimes, National Foundation	(Not available)		
Mental Health Asso., Inc.	Elizabeth Metcalf, Coral Gables	Elva Rath, Lakeland	October 1978
National Multiple Sclerosis Soc.	John R. McGillieaddy, N. Y.	George J. Gillespie III, N.Y.	Chicago, Ill., August 16-21, 1978
Prevention of Blindness, Inc.	Will H. Wasson, Jacksonville	Arthur G. Garrison, Tampa	Tampa, February 1978
Retarded Citizens, Assn. for	Trevor Smith, Tampa	George Williams, Chipley	Tampa, September 14-16, 1978
United Cerebral Palsy, Inc.	James O. Kemp, Jacksonville	Don Asher, Orlando	November 1978

(Most Specialty Group meetings are scheduled at the time of the annual meeting of the Association)

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tropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relation-

ship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.



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